# FAMILY MEDICAL HEALTH CERTIFICATION FORM

***This form should be completed and returned to the site Dow Health Services contact when an employee requests FMLA (Family and Medical Leave Act) leave to care for a family member with a serious health condition.***

**Employee Information** ***(To be completed by Employee)***

**Employee Name:_____ Emp. No. _____**

**Department: _____ Work Phone: _____ Home Phone: _____**

**Leader Name: _____ Leader Work Phone: _____**

**Patient Name and Relationship to Employee: _____**

*Describe the care you will provide to your family member and estimate leave needed, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:*

***Description of Care to be Provided****: _____*

*_____*

***Date of Leave****: Starting on _____ (insert date), ending on _____ (insert date)*

***Leave will be intermittent:*** ***yes*** ☐ ***no*** ☐

(Employee Signature) _____ (Date) _____

**Health Care Provider Information (*To be completed by patient's health care provider)***

1. How does the patient's condition qualify as a FMLA "Serious Health Condition"? *(Please select appropriate response below - See descriptions on back):*

*1. Inpatient Care* ☐ *2. Incapacity Plus Treatment* ☐ *3. Pregnancy/Prenatal Care* ☐ *4. Chronic Condition* ☐ *5. Permanent or Long-term Condition* ☐ *6. Condition Requiring Multiple Treatments* ☐ *7. Absences Attributed to Incapacity* ☐ *8. Does not Qualify* ☐

2. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

3. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[1] if different):

4a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or for safety, or for transportation?

4b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

4c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____ _____

(*Printed Name of Health Care Provider/Type of Practice)*) *(Signature of Health Care Provider)*

_____ _____

(*Address)* *(Telephone Number)*

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PERSONAL AND CONFIDENTIAL

# FAMILY MEDICAL HEALTH CERTIFICATION FORM

***This form can be faxed or mailed to the Occupational Health Facility listed below or given to the employee for return to:***
*Local Health Services Contact Information (Name, Address)* *Phone: XXX-XXX-XXXX Fax number: XXX-XXX-XXXX*

**This form is used**

- To certify and administer requests for family medical leave under Dow's FMLA (Family Medical Leave Act) Policy.

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**SERIOUS HEALTH CONDITION DESCRIPTION – FMLA. (*Your Health Care Provider will NEED the following reference!)***

**A "Serious Health Condition"** means an illness, impairment, or physical or mental condition that involves one of the following:

1. Inpatient Care
   Inpatient care means an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity[(1)] as defined in, or any subsequent treatment in connection with such inpatient care.
2. Incapacity and Treatment
   a) A period of incapacity[(1)] of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
   (1) Treatment[(2)] two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
   (2) Treatment by a health care provider on at least one occasion, which results in a regimen of continuing treatment[(3)] under the supervision of the health care provider.
3. Pregnancy or prenatal care
   Any period of incapacity due to pregnancy, or for prenatal care.
4. Chronic Conditions
   Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:
   (1) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse under direct supervision of a health care provider
   (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   (3) May cause episodic rather than a continuing period of incapacity (1) (e.g., asthma, diabetes, epilepsy, etc.).
5. Permanent or long-term Conditions
   A period of incapacity [(1)] which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
6. Conditions requiring multiple treatments.
   Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, for:
   - Restorative surgery after an accident or other injury; or a condition that would likely result in a period of incapacity*(2)* of more than three consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).
7. Absences attributable to incapacity
   Pregnancy (3) or chronic condition(4) *(of this section)* qualify for FMLA leave even though the employee or the covered family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than three consecutive, full calendar days. For example, an employee with asthma may be unable to report for work due to the onset of an asthma attack or because the employee's health care provider has advised the employee to stay home when the pollen count exceeds a certain level. An employee who is pregnant may be unable to report to work because of severe morning sickness.

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*[1] "incapacity" means inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.*
*[2] "treatment" includes (but is not limited to) examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.*
*[3] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition (e.g., oxygen). A regimen of continuing treatment that includes the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider, is not, by itself, sufficient to constitute a regimen of continuing treatment for purposes of FMLA leave.*