

**METRO Nashville FMLA
Certification for Intermittent Leave Request
Because of Employee's Own Serious Health Condition**

Important Note: *This Certification must be fully completed.* If it is not, we will require the employee to obtain any missing information from you. Until we have complete information, we will be unable to process the employee's request for leave, and the request may be denied. **The health care provider completing this form must review the employee's job description documents prior to completing this Certification.**

Have you reviewed the employee/patient's job description documents prior to completing this Certification? ____ Yes ____ No

Employee Name _____

SERIOUS HEALTH CONDITION

1. Page 10 of this form, (taken from US DOL Form WH-380) describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient/employee's condition qualify under any of the categories described? If so, please check the applicable category:

(1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____, or none ____

2. If "Yes" to Question #1, please state the medical facts that support your certification, including the date the condition commenced and a brief statement as to how the medical facts meet the criteria of one of the listed categories:

Date Condition Commenced:

Medical Facts:

NOTE:

Section A should be completed if the employee's serious health condition creates a foreseeable sequence of absences needed for treatment(s), surgical procedure(s) and/or recovery from those treatment(s) or procedure(s).

Section B (pp. 5) should be completed if the employee's serious health condition creates an unforeseeable sequence of absences and possible need for treatment(s) and/or recovery from those treatments due to "flare-ups" of the employee's chronic serious health condition.

YOU ARE NOT REQUIRED TO COMPLETE BOTH SECTIONS.

A.

LEAVE FOR TREATMENT/RECOVERY

1. Is it medically necessary for the employee to be absent from work on an intermittent basis to receive treatment for and/or to recover from, this serious health condition? (Please keep in mind when answering this question that the term "medically necessary" for intermittent or reduced leave means that there must be a medical need for the leave, as distinguished from ROUTINE OR voluntary treatments and procedures. Also, it must be shown that the medical need cannot be accommodated outside working hours or without having a reduced schedule.)

If you answered yes to Question 1, please continue.

2. Please explain why it is medically necessary and why being absent from work on an intermittent basis is the "best" way to accommodate the employee's serious health condition.
3. Please estimate how long the employee will have this condition.
4. If leave is needed for treatment(s) (including surgical procedures) for this serious health condition, please list:

- a. the dates of all appointments for treatment(s) already scheduled (if none, specify none); or
 - b. an estimate of the probable number of treatments the employee will need during the next 12 months for this condition.
5. As opposed to intermittent leave for appointments for treatment(s) described above, is it medically necessary for the employee to work on a reduced schedule basis prior to or following receiving treatment for this serious health condition?
6. If your answer to Question 5 is “Yes,” and based upon your review of the employee’s job description and normal workweek, what is your best recommendation for a reduction in that workweek?
7. In follow-up to Questions 5 and 6, for what duration do you recommend the employee work on a reduced schedule basis?
8. Have you prescribed a regimen of continuing treatment for the employee due to this serious health condition?
_____ Yes _____ No
9. If your answer to Question 8 is “Yes,” please provide a general description of the regimen.

10. If the employee's job description documents indicate that working mandatory overtime is an essential function of their job, will the employee be able to perform this essential function of their job?
_____ Yes _____ No

If "No," please explain your answer in detail (i.e., why the employee will be able to work their usual shift hours but would be unable to work their assigned overtime).

11. Have you recommended or will you be recommending to the employee that he/she be evaluated or treated by any other health care provider for this condition? _____ Yes _____ No

12. If "Yes," approximately how soon is the employee to see the other health care provider?

13. If "Yes," please provide the other health care provider's:

Name: _____

Type of Practice: _____

Name of Group: _____

Address: _____

Phone: _____

IF YOU HAVE COMPLETED SECTION A, AND SEE NO NEED TO COMPLETE SECTION B, PLEASE GO TO PP. 9 FOR THE SIGNATURE/CERTIFICATION SECTION.

B.

EMPLOYEE'S SERIOUS HEALTH CONDITION – CHRONIC WITH PERIODS/EPISODES OF INCAPACITY (“FLARE-UP’S”)

1. Does the employee have an illness, impairment, or physical or mental condition that: (a) is chronic, ongoing and extends over a period of time; **and** (b) causes a period of incapacity or episodes of incapacity (i.e., the employee will be incapacitated for a partial day, full day, or longer); **and** (c) makes the employee unable to work or be unable to perform other regular daily activities during such periods or episodes of incapacity? Yes No

2. If “Yes” to Question #1, please state the medical facts that support the certification, including the date the chronic condition commenced.

Date Condition Commenced:

Medical Facts:

3. Approximately how long will the employee have the chronic condition?

4. If “Yes” to Question #1:
 - a. Approximately how long is each period or episode of incapacity likely to last (i.e., 1 hour, 2 hours, half a day, 23 hours, one to two days, etc.)?

 - b. Approximately how frequently will the employee have a period or episode of incapacity (i.e., weekly, monthly, semi-monthly, bi-monthly, quarterly, every six months, etc.)?

Please note that you must give an estimate for #4a and #4b above. If you provide “unknown” as an answer to either question, this certification will be incomplete, we will not be able to process the employee’s request for leave, and the employee will be required to obtain the information from you or run the risk of having his/her leave request denied.

5. Is it medically necessary for the employee to be absent from work on an intermittent basis to receive treatment for and/or to recover from, this chronic serious health condition? (Please keep in mind when answering this question that the term “medically necessary” for intermittent or reduced leave means that there must be a medical need for the leave, as distinguished from ROUTINE OR voluntary treatments and procedures. Also, it must be shown that the medical need cannot be accommodated outside working hours or without having a reduced schedule.)

6. If “Yes” to Question #5, please explain why it is “medically necessary” for the employee to be intermittently absent from work because of this chronic serious health condition and why being absent from work on an intermittent basis is the “best” way to accommodate the employee’s serious health condition.

7. Will the employee be required to call or be seen by any health care provider for evaluation or treatment **each time** he/she has a period or episode of incapacity, or a “flare up” of their condition?
_____Yes _____No

8. If “No,” to question 7, please explain why the employee will not be required to consult with or be seen by a health care provider each time. In other words, if the employee is so incapacitated that he/she cannot work or engage in other normal daily activities, why would it not be necessary for the employee to seek medical evaluation or treatment for that particular period or episode of incapacity?

Please keep in mind that “incapacity” means that an employee is unable to work or is unable to perform normal daily activities. If the employee can perform normal daily activities at home, the employee is normally not incapacitated under this definition. If the employee is to simply stay at home and rest (except for doctors appointments and brief necessary trips to obtain medication), please so specify.

9. Please list all the job duties the employee will be **unable** to perform during a period or episode of incapacity or “flare up” of their chronic condition, due to the serious health condition and explain why the employee will be unable to perform them.
10. During a period or episode of incapacity due to the serious health condition, will the employee be unable to work **at all** doing any job (whether with us, for another employer, or in his/her own business)?
_____ Yes _____ No

If “No,” please explain your answer in detail (i.e., why the employee will be unable to work for us but would be able to work for someone else or work at his/her own business).

11. Describe the personal and home activities which the employee may engage in while he/she is having a period or episode of incapacity or “flare up” of their condition, and describe any restrictions there may be on the employee’s home and personal activities.
12. If the employee’s job description documents indicate that working mandatory overtime is an essential function of their job, will the employee be able to perform this essential function of their job?
_____ Yes _____ No

If “No,” please explain your answer in detail (i.e., why the employee will be able to work their usual shift hours but would be unable to work their assigned overtime).

13. Have you prescribed a regimen of continuing treatment for the employee due to this serious health condition?
____ Yes ____ No

14. If your answer to Question 13 is Yes, please provide a general description of the regimen.

15. Have you recommended or will you be recommending to the employee that he/she be evaluated or treated by any other health care provider for this condition? ____ Yes ____ No

16. If "Yes," approximately how soon is the employee to see the other health care provider?

17. If "Yes," please provide the other health care provider's:

Name: _____

Type of Practice: _____

Name of Group: _____

Address: _____

Phone: _____



The undersigned hereby certifies that the above information is true and accurate.

Date Completed: _____

Signature of Health Care Provider: _____

Printed Name: _____

Type of Practice: _____

Name of Group: _____

Address: _____

Phone: _____

Fax: _____

Thank you for your assistance. If you have any questions about this form or the questions on it, please feel free to contact us. ***Please return this form as soon as possible*** to either the employee (who is then required to provide it to us) or return it directly to us by mail or fax at:

Name: _____

Title: _____

Name of Employer: _____

Address: _____

Phone: _____

Fax: _____

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

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity² of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

- (1) **Treatment³ two or more times** by a health care provider, by a nurse or physician’s assistant 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 treatment⁴** under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

- (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician’s assistant 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 incapacity² (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity²** 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. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of Incapacity² of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

³ Treatment includes 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.

- 4 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. A regimen of treatment does not include 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.
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Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.
