



# National Postal Mail Handlers Union

## FMLA CERTIFICATION OF HEALTH CARE PROVIDER

1. Employee's Name: \_\_\_\_\_
2. Patient's Name (if different from employee): \_\_\_\_\_  
Relationship to Employee:      Child       Spouse       Parent
3. The reverse side of this form describes of what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition<sup>1</sup> qualify under the conditions described? If so, please check the appropriate category.  
(a)     (b)     (c)     (d)     (e)     (f)     or None of the above
4. Without stating a specific diagnosis, 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. (a) State the approximate date the condition commenced and the probable duration of the condition: \_\_\_\_\_  
\_\_\_\_\_  
(b) Probable duration of the present incapacity (if different): \_\_\_\_\_  
\_\_\_\_\_  
(c) If the condition is a chronic condition (condition d) or pregnancy, state whether the patient is currently incapacitated<sup>2</sup> and the likely duration of episodes of incapacity: \_\_\_\_\_  
\_\_\_\_\_
6. If additional treatments will be required for the condition, please describe the nature of such additional treatments or continuing regimen of treatment under your supervision (e.g., prescription drugs, physical therapy requiring special equipment); the probable number of such treatments; the length of the employee's required absence for the treatments; and the actual or estimated dates of treatment if known. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. (a) If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform any kind of work:  
\_\_\_\_\_  
\_\_\_\_\_  
(b) If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should provide you with information about the essential job functions):  
\_\_\_\_\_  
\_\_\_\_\_

<sup>1</sup> Here and elsewhere on this form, the information sought only relates to the condition for which the employee is taking FMLA Leave.

<sup>2</sup> "Incapacity," for the purpose of FMLA is defined to mean the inability to attend work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

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

**a. Hospital Care**

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

**b. Absence Plus Treatment**

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

(1) *Treatment 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 *treatment* under the supervision of a health care provider.

**c. Pregnancy**

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

**d. 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 incapacity (e.g., asthma, diabetes, epilepsy).

**e. Permanent/Long-Term Conditions Requiring Supervision**

A period of incapacity 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.

**f. Multiple Treatments (Non-Chronic Conditions)**

Any period of *absence* to receive *multiple treatments* (including *any* period of recovery therefrom) by a health care provider or a provider of health care services under the 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 incapacity 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), kidney disease (dialysis).

---

<sup>1</sup>*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.

<sup>2</sup>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 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.

<sup>3</sup>“*Incapacity*,” for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

(c) If yes, please list the essential functions the employee is able to perform: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(c) If neither (a) nor (b) applies, is it necessary for the employee to be absent from work for treatment:

Yes  No

(d) Will it be necessary for the employee to take time off work intermittently or work on a less than full schedule due to the serious health condition, including treatment?

Yes  No

If yes, give the probable duration and necessary schedule: \_\_\_\_\_  
\_\_\_\_\_

8. (a) 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 needs or personal needs or safety, or for transportation: \_\_\_\_\_  
\_\_\_\_\_

(b) If no, would the employee's presence to provide psychological comfort be beneficial to the patient with a serious health condition who is receiving inpatient or home care. Explain the extent to which the employee is needed to care for the patient or assist in the patients recovery: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(c) If the patient will need care only intermittently or on a part time basis, please indicate the probable duration of this need: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*(Name of Health Care Provider)*

\_\_\_\_\_  
*(Type of Practice)*

\_\_\_\_\_  
*(Signature of Health Care Provider)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Street Address)*

\_\_\_\_\_  
*(City, State, and Zip Code)*

\_\_\_\_\_  
*(Telephone Number)*