



# New York University

## CERTIFICATION OF HEALTH CARE PROVIDER (Family and Medical Leave Act of 1993)

### Health Care Provider ("HCP"): Please complete this form in its entirety\* and sign

Employee: Please submit completed certification as an attachment to Request for Family Medical Leave (FMLA) form to your HR Officer.

(\*Employee is to complete # 9, if request is for leave for family member)

1. Name of EMPLOYEE requesting FMLA:	2a. Name of PATIENT:	2b. Relationship of Patient to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child <input type="checkbox"/> (Age of Child)
3. Check the appropriate serious health condition (refer to next page, "Definition of a Serious Health Condition"): a. <input type="checkbox"/> Hospital Care b. <input type="checkbox"/> Absence Plus Treatment c. <input type="checkbox"/> Pregnancy d. <input type="checkbox"/> Chronic Conditions Requiring Treatment e. <input type="checkbox"/> Permanent/Long-term Conditions Requiring Treatment f. <input type="checkbox"/> Multiple Treatments (Non-Chronic Conditions)		4. <b>Medical Facts</b> (Describe medical facts that support certification identified in #3):
5a. Onset and anticipated duration of condition (if pregnancy, provide expected due date):	5b. Date(s) of patient's <b>present incapacity</b> (if different from 5a):	
6a. Please indicate type of leave requested: [ ] <b>Period of Time</b> : Give duration of time off from work: _____ [ ] <b>Intermittent</b> : Please estimate episodic leave: Frequency of illness episodes: _____ Duration of illness episodes: _____ 6b. Prescribed treatment regimen and schedule (if applicable): [ ] Office visits: # _____ per _____ for (# of days/weeks/months) _____ [ ] Therapy visits: # _____ per _____ for (# of days/weeks/months) _____ [ ] Surgery (date): _____ [ ] Other treatments (type/dates): _____ [ ] Prescription medication [ ] Referral to other providers (describe): _____		
IF FMLA FOR NYU EMPLOYEE'S OWN SERIOUS HEALTH CONDITION: HCP: PLEASE COMPLETE #7		IF FMLA FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION: HCP: PLEASE COMPLETE #8; EMPLOYEE: PLEASE COMPLETE #9
7a. Is in-patient hospitalization of the employee required? [ ] Yes (give dates) _____ [ ] No	8a. Will the patient require assistance for basic medical or personal needs, safety or transportation? [ ] Yes [ ] No	
7b. Is employee unable to perform work of any kind? [ ] Yes [ ] No	8b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? [ ] Yes [ ] No	
7c. 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 employer should supply you with information about the essential job functions)? [ ] Yes [ ] No  If yes, please list the essential functions the employee is unable to perform:	8c. Please indicate duration and frequency/schedule (if applicable) for the need for assistance specified in 8a/ 8b:  9. <b>To be completed by EMPLOYEE requesting FMLA for Family Member</b> : State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:  Signature of Employee and Date: _____	
10a. <b>Print Name of Health Care Provider and Type of Practice</b> (Field of specialization, if any):  Signature of Health Care Provider and Date: _____	10b. Print Address of Health Care Provider:  Office Telephone #:	



## DEFINITION OF A SERIOUS HEALTH CONDITION

*Use this to complete #3 of the Certification of Health Care Provider*

A “serious health condition” means an illness, injury, impairment, 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:

- (a) Treatments 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**
- (b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

### **c. Pregnancy**

Any period of incapacity due to pregnancy or prenatal care.

### **d. Chronic Conditions Requiring Treatments**

A chronic condition which:

- (a) 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;
- (b) Continues over an extended period of time, including recurring episodes of a single underlying condition; **and,**
- (c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes or 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 there from) by a healthcare 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 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), or kidney disease (dialysis).