AbsenceResources®

Completing the FMLA or Leave of Absence Medical Certification Family Member's Serious Health Condition

Instructions for Employee

- ☐ Notify your manager of your need for leave of absence in accordance with City of Savannah's FMLA and leave of absence policies.
- ☐ Ask your family member's health care provider to complete the Medical Certification and provide it (fax number is below) to AbsenceResources within 15 days of the date this letter was sent.
- ☐ Consider following up with your family member's health care provider to confirm the Medical Certification was completed and faxed to AbsenceResources, as it is your responsibility to provide timely, complete and sufficient certification. (Note: you may need to furnish your family member's health care provider with any necessary authorization in order for the health care provider to release a complete and sufficient certification to support the FMLA request.)

AbsenceResources will notify you whether your leave has been approved or denied (via your preferred method communication - email or postal mail) once we receive a complete and sufficient certification. Alternatively, we will notify you if additional information is required. Failure to provide a complete and sufficient medical certificati may result in a denial of your FMLA request.

Instructions for Health Care Provider

Your patient's family member has requested leave to care for the patient. Please answer fully and completely the two sections on the following pages and sign the form.

Step 1 - PATIENT'S CONDITION. Certify whether your patient has a "serious health condition" as the term is defined under the law (note: for more information on the definition of "serious health condition", you can refer to the U.S. Department of Labor website at http://www.dol.gov/whd/fmla/). Also include information sufficient to establish that the patient is in need of care. If your patient's condition does not meet one of the definitions under the law, please indicate that. Do not provide information related to genetic tests or services.

Step 2 - DATES OF LEAVE. Provide the time needed for leave to care for your patient by the family member.

- If the family member's leave is intermittent (described in Step 2) please provide your best estimate of the frequency and duration of the patient's need for care by the family member.
- Terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine whether the patient's condition qualifies for leave.

Step 3 - SIGNATURE. Sign and date the form and provide your type of practice/medical specialty.

Return the completed form via fax to AbsenceResources at 1.877.309.0218 before the listed due date. If you do not complete all steps in full and return it before the due date, AbsenceResources will contact you again to cure any deficiencies or your patient's family member's leave may be denied.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

FMLA or Leave of Absence Medical Certification
Family Member's Serious Health Condition

Family Member Name:
Leave Request #:
Request for leave due to: Family Member's Serious Health Condition
Family member's requested dates of leave:
- Intermittent leave date range request:

Patient Name:
Family Member's Employer: City of Savannah
Due Date:

STEP 1 - PATIENT'S CONDITION.

(A) Describe Appropriate Medical Facts*: Provide a statement or description of appropriate medical facts regardi the patient's health condition for which FMLA leave is requested (i.e., your patient is in need of care by the family member). The medical facts must be sufficient to support the need for leave.

**Such medical facts may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, and any referrals for evaluation or treatments (physical therapy, for example), or any other regimen of continuing treatment such as the use of specialized equipment (Not required in California).*

(B) Select the Appropriate Description of Condition. At least one reason from Section 1 or Section 2 must apply to qualify as a serious health condition under the FMLA and/or state law. *At least one section, and all that apply, must be completed.*

Section 1 - A single reason accounts for the patient's need for care:

- ☐ Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility; or any subsequent recovery or treatment in connection with such inpatient care.
- ☐ Permanent or long-term condition for which the patient is under continuing supervision of a health care provider but for which treatment may not be effective (e.g., Alzheimer's, a severe stroke)
- ☐ Out of work to undergo multiple treatments and related recovery for one of the below:
  (1) restorative surgery after an accident or other injury *or*
  (2) a condition that would likely result in a period of incapacity of more than three (3) full, consecutive calendar days in the absence of such treatment.

Section 2 - A combination of reasons account for the patient's need for care:

- ☐ A period of incapacity of more than three (3) consecutive, full calendar days, coupled with one of the following ***(select at least one and provide the dates of treatment):***
  - ☐ 2 or more in-person treatments within the first 30 days of the patient's incapacity (if not provided b you, please note the medical specialty of the treating provider, e.g., nurse, physical therapist)
    _____
  - ☐ At least 1 examination/treatment followed by a regimen of continuing treatment (e.g. physical therapy or prescription medication), under the supervision of, or referral by a health care provider:
    _____
- ☐ A chronic health condition which continues over an extended period of time and BOTH:
  (1) requires periodic visits for treatment by a health care provider (at least two (2) visits per year) and
  (2) may cause episodic incapacity or flare-ups or would cause periods of reoccurrence without treatment (*e.g.* asthma, diabetes, epilepsy, *etc.*)

Section 3 - The patient does not have a qualifying serious health condition

- ☐ None of the reasons in Sections 1 or Section 2 apply.

(C) Explain the care needed by patient and why the care by the family member is medically necessary.
Why is the employee needed to care for the family member?

Continued on next page

Employee/Patient Name: LR#:

STEP 2 - DATES OF LEAVE

Consider all dates the family member will need to miss work because they are needed to care for your patient by completing the applicable sections below. Dates requested by the family member are listed above. *At least one sectio and all that apply, must be completed.* ***Answers of "unknown," "indeterminate" or "lifelong" may not be sufficien to determine FMLA coverage.***

☐ **Continuous Leave:** *Is the patient in need of care by the family member for a single, continuous period of time?*

i. Start date of need for care ____ / ____ / _____ (MM/DD/YYYY)

ii. Estimated end date of need for care ____ / ____ / _____ (MM/DD/YYYY)

iii. Will the patient require follow-up appointments for which the family member is needed? *If so, please indicate the frequency of incapacity below in section iii under "Intermittent Leave"*

AND/OR

☐ **Intermittent Leave:**
Does the patient's illness or injury require this family member to take occasional time off work?

i. Start date for leave or initial appointment date
____ / ____ / _____ (MM/DD/YYYY)

ii. Probable end date for leave
____ / ____ / _____ (MM/DD/YYYY) ***or***

☐ Condition is lifelong **(check if applicable)**

iii. **Appointments/treatments** - Will the family member need to miss work for appointments or treatments?

☐ No

☐ Yes - Estimate treatment schedule:

Frequency: Up to ____ times per _____ (week/month/year)

Duration: Lasting up to _____ hours **OR** _____ days

Please include the dates of any scheduled appointments and the time required for each appointment:

_____

iv. **Flare-ups/Episodes** - Will the employee need to miss work to care for the patient during episodes of incapacity/flare-ups of the health condition?

☐ No

☐ Yes - Estimate of absences for episodes of incapacity/flare-ups for which this family member is needed?

Frequency: Up to ____ times per _____ (week/month/year)

Duration: Lasting up to _____ hours **OR** _____ days

☐ **Reduced Schedule Leave:**
Does the patient's condition require their family member to work on a <u>FIXED</u> part-time schedule or taking predictable regularly scheduled absences to care for them?

Start date of Leave
____ / ____ / _____ (MM/DD/YYYY)

Probable End Date of Leave
____ / ____ / _____ (MM/DD/YYYY)

Please indicate the number of hours the patient needs care by this family member each day.

Sunday_____

Monday_____

Tuesday_____

Wednesday_____

Thursday_____

Friday_____

Saturday_____

<u>Step 3 - SIGNATURE</u> Health Care Provider Information:

Name: Practice/Specialty/Credentials:

Street Address: Fax Number:

City, State, ZIP Code: Signature:

Phone Number: Date:

AbsenceResources Phone: 866-365-0476 **AbsenceResources Fax:** 877-309-0218

Web Portal: www.absenceresources.com

GINA prohibits employers from requesting genetic information. See instructions on first page.