**Certification of Physician or Practitioner**
**(Family and Medical Leave Act of 1993)**

**Instructions**: To be completed by Practitioner or Physician only. **PLEASE PRINT CLEARY**

| 1. Employee's Name | 2. Patient's Name (if other than employee) |
|---|---|
| _____ | _____ |

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐

☐ None of the above

4. Please state the diagnosis _____ and 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. Date condition commenced _____
   a. Probable duration of condition (and also the probable duration of the patients' present incapacity[2] if different)
   _____
   b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)? If yes, give the probable duration.[2]
   _____
   c. If the condition is a chronic condition (condition 4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.
   _____

6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.
   _____
   b. If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any. _____
   _____
   c. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments.
   _____
   _____

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "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 therefor, or recovery therefrom.

**Continuation**

| Employee's Name | Patient's Name (if other than employee) |
|---|---|
| _____ | _____ |

d. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment).

_____
_____
_____

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 work of any kind? ☐ Yes ☐ No
What are the medical conditions that interfere with the employee performing their assigned duties:

_____
_____
_____

b. If able to perform some work within their title please list the 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

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 or personal needs or safety, or for transportation? ☐ Yes ☐ No

b. 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

c. If the patient will need care only intermittently or on a part-time basis, please describe the kind of care and indicate the probable duration of this need for care by the family member (i.e., the employee).

_____
_____
_____
_____

**Continuation**

| Employee's Name | Patient's Name (if other than employee) |
|---|---|
| _____ | _____ |

I have examined _____ and hereby certify that the above information is correct.

(Name)

_____

(Please print your first and last name)

_____ _____

(Signature of Health Care Provider & Date) (Type of Practice)

_____ _____

(Address) (Telephone number)

**To be completed by the employee needing family leave to care for a family member:**
State the care you will provide and an estimate of the period during which care will be provided. Include a schedule of date(s) and time(s) you will require leave if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

_____
_____
_____
_____
_____
_____

_____ _____

(Employee's signature & Pass #) (Date)

**VOLUNTARY CONSENT**

I _____, give permission for a health care provider representing the New York City Transit Authority, to contact the health care provider that signed my Family Medical Leave Act Medical Certification form, for the purpose of clarifying and/or validating authenticity of the medical certification. Any such inquiry pursuant to this authorization may not seek additional information regarding my health condition or that of a family member.

_____ _____

(Employee's signature & Pass #) (Date)

A **"Serious Health Condition"** means an illness, injury impairment, or physical or medical 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 incapacity[1] or subsequent treatment in connection with or consequent to such inpatient care.

**2. Absence Plus Treatment**

(a) A period of incapacity[1] of more than three consecutive calendar days (including any subsequent treatment or period of incapacity[1] relating to the same condition), that also involves:

(1) Treatment[2] 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[3] 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 incapacity[1] (e.g., asthma, diabetes, epilepsy, etc.).

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[1] "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 therefor, or recovery therefrom.

[2] 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.

[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. 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.

**5. Permanent/Long-term Conditions Requiring Supervision**

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. 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 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[1] 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).

***NOTE:*** Ordinarily, unless complications arise, the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraines, routine dental or orthodontia problems, periodontal disease, etc., are examples of conditions that **DO NOT** meet the definition of a serious health condition and **DO NOT** qualify for FMLA leave.