PHYSICIAN CERTIFICATION
FOR FAMILY OR MEDICAL LEAVE

To Be Completed By Employee:

Employee Name: _____ **Title:** _____

Position/Department: _____ **Supervisor:** _____

Social Security Number: _____ **Employee Number:** _____

I am requesting family or medical leave from work with AWTEC.

The physician or health care provider is treating: _____
(Name Of Patient)

The Patient is: ❒ **Self** ❒ **Spouse** ❒ **Parent** ❒ **Child**

❒ **I am requesting leave from** _____ **until** _____ **or an intermittent or reduced schedule on the following dates:** _____
_____

❒ **(If applicable) I will be providing the following care/services for a family member with a serious health condition on the following dates:**
_____
_____

❒ **(If applicable) The essential functions of my job are (or attach job description).**
_____
_____
_____

To be Completed by Physician or Authorized Health Care Provider

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

   1 2 3 4 5 6 or None of the above

2. 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:
   _____
   _____
   _____

3a. State the approximate date the condition commenced and the probable duration of the condition (and the probable duration of the patient's incapacity, if different):
   _____
   _____
   _____

3b. Will it be necessary for the employee to work only intermittently or to work on a less-than-full schedule, as a result of the condition (including for treatment described in item #4)?
   ❒ Yes ❒ No
   If Yes, give probable duration: _____

3c. If the condition is a chronic condition (Category #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity
   (see page 3):
   _____
   _____

4a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

_____

4b. If any of these treatments are going to be provided by another provider of health services (e.g. physical therapist), please state the nature of treatments:

_____

_____

4c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such a regiment (e.g. prescription drugs, physical therapy requiring special equipment):

_____

_____

5a. 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

5b. 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 supply you with information about the essential job functions.)
❒ Yes ❒ No

If yes, please list the essential functions the employee is unable to perform:

_____

_____

_____

5c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment?
❒ Yes ❒ No

6a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance with medical, personal, safety, or transportation needs? ❒ Yes ❒ No

6b. 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

6c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____

_____ _____ _____

Physician or Authorized Health Care Provider Signature Date Type of Practice

_____

Physician or Authorized Health Care Provider Printed Name

Office Mailing Address: _____

_____

_____ Phone # _____

Employee Signature: _____ Date: _____

Human Resources Approval: _____ Date: _____

Comments: _____

_____

FMLA: What is a "Serious Health Condition"?

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves 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 or subsequent treatment in connection with or consequent to such inpatient care. 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.

2. Absence Plus Treatment

Treatment includes examinations to determine if a serious health condition exists and evaluation of the condition. Treatment does not include routine physical examinations, or dental examinations. 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. 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

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. 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 bedrest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a 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:

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, epilepsy, etc) but, does not necessarily require a visit to a physician at the time of occurrence. For example, a patient with asthma who has been advised to stay home when pollen count is high or a pregnant woman with morning sickness.

5. 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.

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 conditions 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) and kidney disease (dialysis).

Employee Acknowledgement for FMLA Designated Leave

I, acknowledge that I have received a copy of this Notification for FMLA Designated Leave on the following date _____.

I also acknowledge that I have read and understand the terms of this Notification, and have received the medical certification forms that I am required to present to the Company under the terms herein.

Date: _____ Signature: _____

Witness: _____