



## MEDICAL CERTIFICATION STATEMENT

TOOELE CITY HALL • 90 NORTH MAIN • TOOELE, UT 84074 • PHONE 435-843-2105 • FAX 435-843-2106

### **INSTRUCTIONS FOR HEALTH CARE PROVIDER**

Name \_\_\_\_\_ is an employee of Tooele City. You are being asked by this employee to complete a Physician's Verification regarding his/her need for leave. The information sought on this form relates only to the condition for which the employee is taking leave. Please read these instructions prior to completing section B of the following form.

**This form is to be completed by an authorized health care provider** in order to verify the necessity of Family or Medical Leave as requested by the above employee. Under the Family and Medical Leave law, an authorized health care provider:

- is a health care provider recognized by the employer or the employer's group health plan;
- is a doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which he/she practices;
- is a podiatrist, dentist, clinical psychologist, optometrist or chiropractor (limited to manual manipulation of the spine to correct a subluxation found by X-Ray to exist) authorized to practice, and performing within the scope of their practice, under state law;
- is a nurse practitioner, nurse-midwife or clinical social worker authorized to practice, and performing within the scope of their practice, as defined under state law; or
- is a Christian Science practitioner listed with the First Church of Christ, Scientist in Boston, MA.

**Please read the following definitions before completing this form.**

After receiving this completed form, the employer is not permitted to contact the health care provider for additional information. A health care provider representing the employer may contact the health care provider for clarification of information contained on this form.

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, eye 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;
- 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 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.

#### **3. Pregnancy**

Any period of incapacity due to pregnancy or 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 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 of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer, radiation, etc.), severe arthritis (physical therapy) and kidney disease (dialysis).



# PHYSICIAN CERTIFICATION FOR FAMILY OR MEDICAL LEAVE

This form contains medical-related information and must be maintained in files separate from employee personnel files, in locked cabinets with only designated persons having access.

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Name \_\_\_\_\_

### SECTION A: THIS SECTION TO BE COMPLETED BY EMPLOYEE

I am requesting Family or Medical Leave from Tooele City Corporation. Please complete the following Physician's Verification on my behalf.

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 or periods: \_\_\_\_\_

(If applicable) I will be providing the following care/services for a family member under your care who has a serious health condition. I will be providing care for the following dates: \_\_\_\_\_

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### SECTION B: THIS SECTION TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED HEALTH CARE PROVIDER AFTER REVIEWING INSTRUCTIONS

1. A description of what is meant by a "serious health condition" under the Family and Medical Leave Act is included in the **Health Care Provider Instructions** included with this form. 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 described conditions

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: \_\_\_\_\_

3. 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): \_\_\_\_\_

4. 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: \_\_\_\_\_

5. If leave is required because of the employee's own condition (including absence due to pregnancy or a chronic condition), is the employee able to perform work of any kind?  Yes  No

6. If the employee can perform some work, what specific duties is the employee unable to perform? (The employee should supply you with information about his/her job.) \_\_\_\_\_

7. Will it be necessary for the employee to be absent 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 and details on what Tooele City should expect as reasonable: \_\_\_\_\_

8. If no restrictions apply, is it necessary for the employee to be absent from work for treatment?  Yes  No

a. If yes, provide an estimate of the probable number of such treatments: \_\_\_\_\_

b. 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 the treatments: \_\_\_\_\_

c. If a regimen of continuing treatment of the patient is required, provide a general description of such a regimen (e.g., prescription drugs, physical therapy requiring special equipment): \_\_\_\_\_

9. If prescription drugs are prescribed, is the employee able to perform safety sensitive duties?  Yes  No

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_