

## CERTIFICATION OF HEALTH CARE PROVIDER FORM \*

*University of New Hampshire  
Information on this form is confidential and private.*

### 1. To Be Completed by Employee

#### 1a. EMPLOYEE INFORMATION

Employee's Name (Last, First, MI)	SS # (Last 4 Digits)
Home Address (City, State, ZIP)	UNH Department

#### 1b. IF LEAVE REQUEST IS FOR THE CARE OF A FAMILY MEMBER

Patient's Name (Last, First, MI)	Relationship to Employee
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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 if it will be necessary for you to work less than a full schedule.

### 2. To Be Completed by Health Care Provider *(Re-certification may be required)*

For Medical Condition of *UNH Employee* – Please complete Sections 2a through 2c, and Section 3  
For Medical Condition of *Employee's Family Member*– Please complete Section 2f and Section 3

#### 2a. SERIOUS HEALTH CONDITION

Does the patient's condition<sup>1</sup> qualify under any of the categories described?    \_\_\_ Yes    \_\_\_ No  
If so, please check the applicable category.

1. Hospital Care                       2. Absence Plus Treatment                       3. Pregnancy                       4. Chronic Conditions Requiring Treatments  
 5. Permanent/Long Term Conditions Requiring Supervision                       6. Multiple Treatments (Non-chronic Conditions)                       7. None of the above

Page 4 describes what is meant by a "serious health condition" under the Family Medical Leave Act.

#### 2b. MEDICAL FACTS

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:

\* This form applies to faculty and staff medical leave including Family and Medical Leave Act of 1993. It also pertains to situations in which the faculty or staff member may not be taking medical leave but medical information is needed to provide adjustments or accommodations.

<sup>1</sup> Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

**2c. DATES**

I. Approximate date the condition commenced \_\_\_\_\_

Stop work date (date leave begins) \_\_\_\_\_

Return to work date \_\_\_\_\_

Probable duration of the condition \_\_\_\_\_

Probable duration of the patient's present incapacity<sup>2</sup> if different \_\_\_\_\_

Will the condition be in effect for more than six months?     \_\_\_ Yes     \_\_\_ No

For maternity leave: Due date \_\_\_\_\_

Date leave begins (if different from Due Date) \_\_\_\_\_

Return to work date (when medically able to return to work; normally six weeks following the birth) \_\_\_\_\_

II. Will it be necessary for the employee to work intermittently or to work on a less than full schedule as a result of the condition (including treatment as described in Item 6, on page #4)?     \_\_\_ Yes     \_\_\_ No

If yes, please give the probable duration and describe schedule:

III. If the condition is a chronic condition (condition #4, on page #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity<sup>2</sup>:

**2d. TREATMENTS<sup>3</sup>**

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

II. 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 of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

III. If any of these treatments will be provided by another provider of health service (e.g., physical therapist), please state the nature of the treatments:

IV. 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):

<sup>2</sup> "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 there from.

<sup>3</sup> 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.

**2e. ABILITY TO PERFORM WORK**

I. If medical leave is required for the employee's absence from work because of the employee's own health condition (including absences due to pregnancy or a chronic condition), is the employee able to perform work of any kind?  
 \_\_\_\_\_ Yes    \_\_\_\_\_ No

II. 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)?

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

III. If neither I. nor II. applies, is it necessary for the employee to be absent from work for treatment?  
 \_\_\_\_\_ Yes    \_\_\_\_\_ No

**2f. FAMILY CARE LEAVE**

I. 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

II. 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

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

**3. SIGNATURE AUTHORIZATION**

**3a. SIGNATURE OF HEALTH CARE PROVIDER**

Signature	Name and Title (Please Print)	Date
Type of Practice		Telephone
Address (Please Print)		Fax

**3b. SIGNATURE OF EMPLOYEE**  
 I authorize release of the information requested on this form.

Signature	Name and Department (Please Print)	Date
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Return forms to:  
 Office of Human Resources  
 University of New Hampshire  
 2 Leavitt Lane  
 Durham, NH 03824  
 (fax): 603-862-0517

## Definitions of Serious Health Condition

A “Serious Health Condition” means an illness, injury impairment, or physical or mental 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 incapacity or subsequent treatment in connection with or consequent to such inpatient care.
2. **Absence Plus Treatment**  
(a) 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:
  - (1) 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
  - (2) Treatment by a health care provider on at least one occasion which results in a **regimen of continuing treatment**<sup>4</sup> under the supervision of the health care provider.
3. **Pregnancy**  
Any period of incapacity due to pregnancy, or 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 (e.g. asthma, diabetes, epilepsy, etc.).
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 a 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) and kidney disease (dialysis).

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<sup>4</sup> A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., 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; bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

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