

**CITY OF PROVIDENCE – DEPARTMENT OF HUMAN RESOURCES
 FAMILY MEDICAL LEAVE REQUEST &
 CERTIFICATION OF PHYSICIAN OR PRACTITIONER
 (Family and Medical Leave Act of 1993)**

FAMILY MEDICAL LEAVE REQUEST

Instructions to Employee:

Complete this section and have your doctor complete the section below. This form must be filled out **completely** and **accurately**. Return it to your Department Director or to the Personnel Director.

Name of Employee (please print):	Social Security #:	Department:	Date of Hire:	Last day worked:
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Reason for FMLA Request:

I certify that all facts presented above are true and hereby request leave in accordance with the City of Providence policy:

(Signature/Date)

X **X**

Department Director Review (Signature/Date) **Human Resources Director Approval (Signature/Date)**

X **X** **X** **X**

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

1. Patient's Name (if other than employee)	Relationship to employee: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
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2. Serious Health Condition
 Refer to page 3 for descriptions. If the patient's condition qualifies, please check the applicable category.
 Hospital Care Absence plus treatment Pregnancy Chronic condition requiring treatments Permanent/long term conditions req. treatment Multiple treatments (not chronic cond.)

3. Describe the medical which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

4a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's incapacity if different):

4b. 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 5 below)? Yes No

If yes, give the probable duration:

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

5a. If additional treatments will be required for the condition, provide an estimate of the probable number of such

treatments:

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:

5b. 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:

5c. 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):

6a. 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?

6b. 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)?

6c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment?

7a. 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?

7b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

7c. If the patient will need to work only intermittently or on a part-time basis, please indicate the probable duration of this need?

Print Name of physician or practitioner:

Phone number:

Address:

Type of practice (field of specialization)

Signature of Physician or Practitioner and date

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 of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **ABSENCE PLUS TREATMENT**

A period of incapacity of more than three 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, health care provider, or
2. 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.

3. **Pregnancy**

Any period of incapacity due to pregnancy, or for prenatal care.

4. **Chronic Conditions Requiring Treatments**

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 in nature or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the 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 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).

