

SYBIL F. BAILEY
Director of Human Resources

DAVID N. CICILLINE
Mayor



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the physician, _____
(Please ***print*** name of physician)

to speak with Sybil Bailey, Director of Human Resources, and/or her designee for the purpose of obtaining medical information in relation to myself or my family member which involves my ability to perform the duties of my job. I further give Sybil Bailey permission to discuss my medical conditions or those of my family member with Donald Iannazzi, Esq., Business Manager- Local Union 1033, as necessary.

_____, **2004** _____
Date **Signature**

Physician's Street Address, City, State, Zip Code

Physician's Phone Number

**Certification of Health Care Provider
(Family and Medical Leave of Act of 1993)**

1. Employee's Name: _____

2. Patient's Name/Relationship (if different from 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 check the applicable category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____, or None of the above _____

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

5a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patients present incapacity ² if different)

b. 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 the item 6 below)?

If yes, give the probable duration: _____

c. If the condition is a chronic condition, (condition #4) or pregnancy, state whether the patient is presently incapacitated ² and the likely duration and frequency of episodes of incapacity ²

6a. 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: _____

b. Therapists, please state the nature of the treatments: _____

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

"Incapacity" for the purposes of FMLA, is defined to mean inability to work, attend school, or perform regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

c. If 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) _____

7a. If medical leave is required for the employees absence from work because of the employee's own condition (including absences due to pregnancy or chronic condition), is the employee unable to perform work of any kind? _____

b. If unable 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 this employee is able to perform: _____

c. If neither a nor b applies, is it necessary for the employee to be out of work for Treatment? _____

8a. 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? _____

b. If so, would the employee's presence to provide physiological comfort be beneficial to The patient or assist in the patient's recovery? _____

c. If the patient will need care only intermittently or on a part – time basis, please indicate the probable Duration of this need: _____

(Signature of Health Care Provider)

(Type of Practice)

(Address)

(Telephone Number)

(Today's Date)

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.

(Employee Signature)

(Date)

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 ² or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**

(a) A Period of incapacity ² of more than three consecutive calendar days (including any period of Incapacity ² relating to the same condition), that also involves:

- (1) Treatment ³ 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 a 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 treatment⁴ 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) May be episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.)

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.

A regimen of continuing treatments 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 does not include the taking of over-the-counter medications such as aspirin, antihistamines, salves, bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Permanent/Long Term Conditions Requiring Supervision

A period of incapacity² which is permanent or long term due to 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.

5. **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 incapacity² 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).