SAMPLE FORM FOR CHILD WITH CHRONIC CONDITION

HEALTH CARE PROVIDER CERTIFICATION OF EMPLOYEE'S FAMILY MEMBER SERIOUS ILLNESS – FMLA

Employee's name Mary Hines

Patient's name John Hines

Relationship to employee ___ Spouse ___ Parent X Child (under age 18 or if older and incapable of self care due to a mental or physical disability)

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.*

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

Describe the medical facts and/or treatment that meet the criteria of the category checked above (Medical diagnosis/prognosis is not required). The patient was seen by me today and will be seeing me every 6 weeks for treatments. He has been under my care since 2005.

Date condition commenced: 2005 **Probable duration of condition:** 5 years

Probable duration of present incapacity (if different): April 1-3, 2009

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? X **Yes** _____ **No**

If no, would the employee's presence to provide psychological comfort be beneficial to the patient's recovery? _____

Note the probable duration of the need. _____

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment of the family member's serious health condition (e.g. follow-up treatment)? X **Yes** _____ **No**

If so, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:

Dates: May 15 and every 6 weeks after that

Duration: 4-8 **hour(s) or** _____ **day(s) per episode.**

Period of Recovery: 1 day

Will the employee require leave on an intermittent or reduced schedule basis for the family member's serious health condition, that may result in unforeseeable episodes of incapacity (e.g. flare ups)? X **Yes** _____ **No**

If so, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: 1-2 **times per** 4 **week(s)** 6 **month(s):**

Duration: 8-16 **hour(s) or** 1-2 **day(s) per episode.**

If the employee requires leave on an intermittent or reduced schedule basis to care for a covered family member with a serious health condition, briefly explain why such care is medically necessary (this can include assisting in the family member's recovery).

Mrs.Hines will need to transport her son for his treatments and stay with him in case of reaction.

Health Care Provider's Name (Please print): John William, MD

Health Care Provider's Signature: John William, MD **Date:** April 1, 2009

Address: 625 Main St

Phone number: 555-555-5555 **Fax number:** 666-666-6666

Specialty/Type of Practice: Pediatrician