CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS – FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's name MARY JONES

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

Describe the medical facts and/or treatment that meet the criteria of the serious health condition checked above (Medical diagnosis/prognosis is not required): I EXAMINED MS. JONES TODAY FOR A REPIRATORY PROBLEM THAT WILL BE TREATED WITH PRESCIBED MEDS AND FOLLOW UP VISIT NEXT WEEK.

Date condition commenced: MARCH 25, 2009
Probable duration of condition: 4-10 DAYS
Probable duration of present incapacity (if different): _____

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment (e.g. follow-up treatment) of the employee's serious health condition, including pregnancy? X **Yes** _____ **No**
If so, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:
Dates: APRIL 3, 2009
Duration: 8 **hour(s) or** 1 **day(s) per episode.**
Period of Recovery: NEXT DAY

Will the employee require leave on an intermittent or reduced schedule basis for the employee's serious health condition, including pregnancy, that may result in unforeseeable episodes of incapacity (e.g. flare ups)? _____ **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: _____ **times per** _____ **week(s)** _____ **month(s):**
Duration: _____ **hour(s) or** _____ **day(s) per episode.**

Is the employee able to perform the essential functions of employee's position? YES **If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.**

_____

_____

Health Care Provider's Name (Please print): DAVID SMITH, MD

Health Care Provider's Signature: S/ DAVID SMITH MD **Date:**

Address: 87 OAK DRIVE DENVER CO 80025

Phone number: 789-567-2345 **Fax number:** 789-555-6662

Specialty/Type of Practice: FAMILY PRACTICE