

THE CITY UNIVERSITY OF NEW YORK
The College of Staten Island

CUNY FMLA Certification of Health Care Provider

Please complete this form in its entirety. **Print** or type all information provided unless a signature is requested.

<p><u>Instructions for Employee/Patient</u></p> <ol style="list-style-type: none"> 1. Complete Section A. 2. Give form to your health care provider and request the provider to complete and return the form directly to you. 3. Bring the form to Human Resources no later than 15 days following the date you received the form. 	<p><u>Instructions for Health Care Provider</u></p> <ol style="list-style-type: none"> 1. Complete Sections B-D. 2. Return to employee/patient within two weeks of receipt of form. 3. If you have any questions, contact The Human Resources Office
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Section A: To Be Completed by the Employee

Name:	Department:	Phone Number: Office - Home -
Supervisor's Name:	Supervisor's Title:	Supervisor's Phone Number:
Patient's Name (if different from above):	Relationship of Patient to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child	
Employee Signature:		Date:

Section B: To Be Completed by Health Care Provider

The City University of New York fully complies with the Family and Medical Leave Act (FMLA) of 1993, which provides benefits and job protection for eligible employees facing their own "serious health condition" or that of a family member. Under FMLA, a serious health condition is defined as an illness, injury, impairment or physical or mental condition involving any one or more of the qualifying treatments and conditions cited below. The above-named employee is requesting a family and medical leave of absence for his/her own serious health condition or that of a family member. Kindly check all treatments/conditions that apply.

Hospital Care, Inpatient Care – This is defined as 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. (**Note:** Incapacity means inability to work, attend school or perform regular daily activities due to the serious health condition, associated treatment, or recovery from treatment/condition)

Absence Plus Treatment – A period of incapacity of **more than three (3) 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** under the supervision of the health care provider.

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

Chronic Conditions Requiring Treatments – For FMLA purposes, a **Chronic condition** 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 or epilepsy.)

Permanent or Long-term Conditions Requiring Supervision – This condition is defined as a period of **incapacity** which is **permanent or long because of** 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.

Section B: (Continued)

Multiple Treatments for Non-Chronic Conditions – This situation is defined by any period of absence to receive **multiple treatments** 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 (3) consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, or radiation), severe arthritis (physical therapy), and kidney disease (dialysis). This also includes any time off for a period of recovery from treatments.

Section C: To Be Completed by Health Care Provider

Describe the **medical facts of patient** supporting your certification that would help us understand how the patient's condition meets one of the "Serious Health Condition" categories you checked.

Indicate whether incapacity is episodic, periodic, or extended, and the approximate date the condition commenced.

If additional treatments or a regimen of treatments will be required (by you or under your supervision), please provide a general description of the regimen (*e.g.*, prescription drugs, physical therapy requiring special equipment.)

If the employee will be absent from work on an intermittent or part-time basis, please provide the following:

Probable number of treatments _____ Interval between treatment _____

Dates of treatment if known _____ Period required for recovery if any _____

If FMLA leave is for a family member, explain whether the family member requires physical and/or psychological assistance or comfort from the employee.

What is the actual or estimated duration of any incapacity of employee or the family member?

Employee's return to work date:

Section D: To Be Completed by Health Care Provider

Health Care Provider's Name:

Type of Practice:

Address:

Phone Number:

Health Care Provider's Signature:

Date: