NYC HEALTH + HOSPITALS

Certification of Health Care Provider for Family Member's Serious Health Condition Family and Medical Leave Act (FMLA)

Instructions:

- **The employee must complete Section 1, then have their Health Care Provider complete Section 2, and then the employee must submit the completed form to HRSSLeaveAdministration@nychhc.org.**
- **REMINDER**: Timely submission of request is important. As a general rule, approved leaves will not be effective more than 15 calendar days retroactively from the date of receipt of completed forms to HRSS Leaves at HRSSLeaveAdministration@nychhc.org. Incomplete forms will not be processed. FMLA runs concurrently with all other eligible leaves.
- Please note employees may be eligible for Paid Family Leave (PFL) for Bonding, and the serious health condition of a family member processed by third party administrator AbSolve at 800-401-2691. Additional information can be found in the Employee Resources Center under Leaves of Absence on the intranet. Please note: At no point can you be paid by 3rd party administrator, Absolve and NYC H+H Payroll. It is the employee's responsibility to recoup any overpayment.

SECTION 1 – To be completed by Employee, the Caregiver (please print):

Last Name, First Name, Middle Initial:	**Employee ID #:**
Facility / Business Unit:	**Employee's Job Title:**
Name of Family Member for Whom You Will Provide Care:	**Employee's Personal Email:**

Select the relationship of the family member you will care for (must submit proof of relationship selected). The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18 ☐ Child, *age 18 or older and incapable of self-care because of a mental or physical disability*

Note: Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child or to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Select the leave type you are requesting and provide details:

☐ **Continuous** (2+ weeks) **Start Date** _____ **and End Date** _____

☐ **Intermittent** _____ hours per week **OR** _____ days per week **OR** _____ days per month **OR** _____ hours per month

Additional details you would like to be considered part of your request:

SECTION 2 – To be completed by Health Care Provider:

Please provide your contact information, complete all relevant parts of this Section, and sign the form. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider.

Health Care Provider's Name (Print): _____

Health Care Provider's Business Address: _____

Type of Practice / Medical Specialty: _____ **License #:** _____

Phone Number: _____ **Email:** _____

PART A – Medical Information (to be completed by Provider)

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed**. *Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Failure to complete this form in its entirety, may create delays for employee's leave request.*

(1) **Patient's Name:** _____

(2) **State the approximate date the condition started or will start:** _____

(3) **Provide your best estimate of how long the condition lasted or will last:** _____

Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided.

☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity Plus Treatment:** *(e.g. outpatient surgery, strep throat)*

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).*

☐ **Pregnancy:** The condition is pregnancy. The expected delivery date is: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions:** *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long-Term Conditions:** *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions Requiring Multiple Treatments:** *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the Above:** If none of the above condition(s) were checked and there is no serious medical condition to be considered, (e.g. inpatient care, pregnancy), go to page 3 to sign and date the form.

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee (the caregiver) seeks FMLA leave. (e.g., use of nebulizer, dialysis): _____

_____

PART B – Amount of Leave Needed by NYC H+H Employee Providing Care for Family Member

For the medical condition(s) checked in Part A, complete all that apply. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s). State the nature of such treatments: (e.g. cardiologist, physical therapy): _____

Provide the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the treatment(s).

(7) Due to the condition, the patient (☐ is / ☐ will be) incapacitated for a **continuous** period of time, including any time for treatment(s) and/or recovery.
Provide your best estimate of the beginning date _____ (mm/dd/yyyy) and end date for the period of incapacity _____ (mm/dd/yyyy).

(8) Due to the condition, it (☐ is / ☐ will be) medically necessary for the employee (the caregiver) to be absent from work on an **intermittent** basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.
Over the next _____ months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ hours / _____ days, per episode.

_____ _____

Signature of Health Care Provider **Date** (MM/DD/YYYY)

Definitions of a Serious Health Condition
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: • Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, • At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.