**Family and Medical Leave Act**  
**STATE SYSTEM OF HIGHER EDUCATION**  
**Serious Health Condition Certification**  
**Family Member Form**

### FOR THE EMPLOYER TO COMPLETE:

<table>
<thead>
<tr>
<th>Employee</th>
<th>Employee Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency</th>
<th>Work Location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FOR THE EMPLOYEE TO COMPLETE:

<table>
<thead>
<tr>
<th>Family Member / Patient Name</th>
<th>Family Member Relationship to Employee</th>
<th>Family Member Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Does the family member require assistance for basic medical, hygienic, nutritional, safety, or transportation needs?**

- [ ] Yes  
- [ ] No

**How will the leave be used (intermittently, as needed, on a specific schedule, etc.)?**

**What type of care will you be providing while using the leave (be specific)?**

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FOR THE HEALTH CARE PROVIDER TO COMPLETE:

1. **When did the condition commence?**

2. **When did the incapacity commence?**

3. **Is the patient presently incapacitated?**

- [ ] Yes  
- [ ] No

   **If no, when did the incapacity cease?**

   **A. If yes, does the patient require assistance for basic medical, hygienic, nutritional, safety, or transportation needs?**

   - [ ] Yes  
   - [ ] No

   **B. If yes, what are the physical or mental impairments that require the employee to be absent from work to attend to the patient?**

4. **Has a regimen of continuing treatment been prescribed?**

- [ ] Yes  
- [ ] No

   **A. If yes, please describe the type of treatment, i.e. physical therapy, prescription drugs, etc.**

   **B. If yes, has regimen been completed?**

   - [ ] Yes  
   - [ ] No

   **If yes, when was the regimen completed?**

5. **Are additional treatments required for this condition?**

- [ ] Yes  
- [ ] No

   **A. If yes, where will the treatments be provided? If not in your office, will you remain involved with the treatment?**

   **B. If yes and if known, what are the dates of the next several treatments? How long will treatments continue?**
6. Will it be necessary or possible for the employee to care for the patient intermittently or part-time?
   - Yes
   - No

   A. If yes, what is the schedule?

   B. If yes, what is the probable duration of such intermittent or part-time care?

7. Upon recovery, is it likely that episodes of incapacity will arise? If yes, how frequently?
   - Yes
   - No

A "serious health condition" is an illness, injury, impairment, or physical or mental condition. Please check all blocks that apply to the patient's serious health condition.

- **Hospital Care.**
  Inpatient (not outpatient) care 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.

- **Absence Plus Treatment.**
  A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that 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 (ex. 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 a health care provider. A regimen of continuing treatment does not include taking over-the-counter medications, bed-rest, drinking fluids, exercise, or other similar activities that could be initiated without a visit to a health care provider.

- **Pregnancy.**
  Any period of incapacity due to pregnancy or for prenatal care.

- **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 the 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 (asthma, diabetes, epilepsy, etc.)

- **Permanent/Long-term Conditions Requiring Supervision.**
  A period of incapacity which is permanent or long-term due to 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, severe stroke, or the terminal stages of a disease.

- **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 incapacity 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).

- **None of the above.**

Describe the medical facts and how they support the above selected serious health condition category.

<table>
<thead>
<tr>
<th>Signature of Health Care Provider</th>
<th>Type of Practice</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider Name and Address (please print)</td>
<td>Health Care Provider Telephone Number</td>
<td></td>
</tr>
</tbody>
</table>