AMERICAN POSTAL WORKERS UNION, AFL-CIO
INDUSTRIAL RELATIONS DEPARTMENT

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: _____

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
__ 4. **Chronic Condition**
__ 5. **Permanent Long-term Condition**
__ 6. **Multiple Treatments** (Non-Chronic Condition)

Describe the medical facts and/or treatment that meet the criteria of the serious health condition checked above. This may include symptoms; nature of the condition; dates of treatment; or any regimen of continuing treatment such as a course of prescription medication or therapy requiring use of specialized medical equipment. ***Medical diagnosis/prognosis is not required***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

_____

_____

_____

_____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? _____

On which dates did you treat the employee in the past 12 months? _____

How long do you project the condition to continue? _____

How long will the employee be incapacitated (if different)? _____

How long will the employee need to be on leave because of the condition? _____

_____

Will the employee need treatment at least twice per year for the condition? ___ Yes ___ No

Will the employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? ___Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _____

Frequency of treatment/episodes of incapacity: ___ times per ___week ___ month

Duration of treatment/episode of incapacity: ____hour(s) or ____ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: _____

Is the employee able to perform the essential functions of employee's position and job duties?
___ Yes ___No

If no, describe the physical restrictions, accommodations or modification of job duties required: _____

_____

IV. HEALTH CARE PROVIDER SIGNATURE

Dated: _____ By: _____

Health Care Provider's Name (Please print): _____

Address: _____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _____