

**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 ELM. Form PS 3971 must be completed by employee.

EMPLOYEE'S NAME **JOHN DOE**

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.)

(1) X (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ None of the above _____

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above. **MR. DOE WAS HOSPITALIZED SURGERY AND HAS BEEN SCHEDULED FOR FOLLOW-UP VISITS AND COULD EXPERIENCE FLARE-UPS OF HIS CONDITION.**

Date condition commenced: **6/26/95**
Probable duration of condition: **SIX MONTHS**
Probable duration of the present incapacity (if different): **FOUR WEEKS**

Will the employee be required to be off from work intermittently or work a reduced schedule as a result of this condition and/or treatments? **YES** Note the probable time and duration. **1 TO 2 DAYS PER MONTH FOR THE NEXT 6 MONTHS**

If the condition is chronic (#4) or pregnancy (#3), note if the employee is presently incapacitated and the likely duration and frequency of episodes of incapacity.

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known. **ONE OFFICE VISIT PER MONTH ON OR ABOUT THE 15TH OF EACH MONTH FOR THE NEXT SIX MONTHS**

Is the employee able to perform the functions of employee's position? **NO** If no, describe the physical restrictions placed on the employee, including the duration of such restrictions. **MR. DOE WILL BE UNABLE TO PERFORM ONE OR MORE FUNCTIONS OF THIS POSITION FOR THE NEXT FOUR WEEKS AND WILL BE UNABLE TO DO SO DURING ANY OF THE FLARE-UPS NOTED ABOVE.**

Health Care Provider's Signature & Type of Practice	DR. GET BETTER SURGEON	Date	6/26/95
Address	1 MEDICAL PLACE BIG CITY USA		

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