Print Form

State of Colorado Medical Certification Form

Employee's Health Condition

Instructions to Department/Institution: For the employee's condition, fill in the following. You may attach the job duties from the official PDQ. Please complete this portion before giving to the employee. This completed form is to be placed in a separate, confidential medical file with limited access.

Pursuant to the Genetic Information Nondiscrimination Act (GINA)'s "safe harbor" provision in 29 CFR § 1635.8(b)(1)(i), the GINA disclosure language (see instructions for Healthcare provider) must be included with any request for employment-related medical information or examinations (e.g., FMLA for employee, ADA, Fitness-for-Duty exams, Workers' Compensation exams, post-offer/pre-employment exam, etc.) for the individual's own condition.

Employee's job title:	Regular work schedule:
Essential functions of the job:	Check if job duties list is attached: _____

Instructions to Employee: Fill in your name and employee ID # prior to giving this form to your health care provider. If this document is returned incomplete, or contains vague/ambiguous responses, it will be returned to you for correction. Failure to provide a complete and sufficient certificate within 15 calendar days may result in denial of paid leave and the possible delay or denial of any applicable family/medical leave. Providing false information, knowingly, either directly or through another party, may result in corrective and/or disciplinary action.

Employee's Name:	Employee ID:

Employee signature: _____ Date: _____

Instructions to Health Care Provider: Please limit your responses ***only*** to the condition for which the employee is seeking leave. In order to avoid potential adverse consequences for the employee, please answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. 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. Be sure to sign the form on the last page and return to the employee.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name and business address:	Type of practice/medical specialty:
Telephone: ( )	Fax: ( )

Definitions for Medical Certification Form

"Serious Health Condition" is an illness, injury, impairment, or physical or mental condition that involves one of the following.

1. Inpatient Care.

   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or any subsequent treatment in connection with such inpatient care.

2. Incapacity and 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 also involves:

   (1) **Treatment two or more times within 30 days of the first day of incapacity**, unless extenuating circumstances exist, by a health care provider, by a nurse under the direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under order of, or 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.

   Treatment by a healthcare provider means an **in-person visit** to a health care provider. The first or only in-person treatment visit **must take place within 7 days of the first day of incapacity**.

3. Pregnancy or prenatal care.

   Any period of incapacity due to **pregnancy**, including **prenatal care**.

4. Chronic Conditions Requiring Treatments. A **chronic condition** which:

   (1) Requires **periodic visits** (**at least twice a year**) for treatment by a health care provider, or by a nurse under the direct supervision of a health care provider; **AND**

   (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, epilepsy).

5. 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 patient must be **under continuing supervision of, but need not be receiving active treatment by, a health care provider** (e.g., Alzheimer's, severe stroke, terminal stage of a disease).

6. Multiple Treatments (Non-Chronic Condition).

Any period of absence to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or 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), severe arthritis (physical therapy), kidney disease (dialysis).

"Treatment" includes examinations to determine if a serious health condition exists and evaluations of the condition. It does not include routine examinations.

"Regimen of Continuing Treatment" includes, for example, a course of prescription medication (e.g., antibiotics) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

"Incapacity" is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

Serious Health Condition

1. The above definitions describe a "serious health condition" under the Family Medical Leave Act. Does the patient's condition meet one of these categories? Please check the category.
(1)____ (2)____(3)____(4)____(5)____(6)____, or none.

2. Describe specific **medical** facts related to the condition for which the employee seeks leave and meets the category (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

Additional Medical Facts (must be completed)

1. Approximate date the condition began: _____
2. Probable duration of the condition: _____

Mark As Applicable:

1. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
No ____Yes ____ If so, dates of admission: _____

Date(s) you treated the patient for the condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition? No____ Yes_____

Was medication, other than over-the-counter medication, prescribed? No ____Yes ____

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? No____ Yes____. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No____ Yes ____. If so, expected delivery date: _____

3. Refer to the list of essential functions provided above or attached by the employer. If there is no list of essential functions, base your answers on the employee's description of their job functions.

Is the employee unable to perform any of his/her job functions due to the condition? No____ Yes ____ If so, identify the job functions the employee is unable to perform:

Amount of Leave Needed

4. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No ____ Yes ____ If so, estimate the beginning and ending dates for the period of incapacity:

5. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No ____ Yes ____

If so, are the treatments or the reduced number of hours of work medically necessary? No____ Yes ____

Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:
_____ hour(s) per day _____ days per week from _____ through _____

6. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No____ Yes____.

Is it medically necessary for the employee to be absent from work during the flare-ups? No ____ Yes ____
If so explain: _____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of the related incapacity that the patient may have over the next 6-months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ____times per week(s) or ____ times per months(s) Duration: ____hours or ____days(s) per episode

Additional Information (identify question number with your additional answer)

Signature of Health Care Provider _____Date _____

Print Name _____

Return completed form to the employee