

CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993)

TO BE COMPLETED BY THE EMPLOYEE:

Employee's Name:	Job Title:
Employee's Phone Number:	Service Unit or Department:
Employee's SSN or Employee ID:	Supervisor:
Reason for leave: <input type="checkbox"/> Birth of an employee's Child (Estimated due date _____) <input type="checkbox"/> Own Serious Health Condition Care of: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Child (age _____)	Type of Leave: <input type="checkbox"/> Block <input type="checkbox"/> Intermittent <input type="checkbox"/> Reduced Work Schedule

Qualified employees have a right under the Family and Medical Leave Act of 1993 (FMLA) for up to 12 weeks of unpaid leave during the calendar year for reasons listed above. By signing this form I agree to allow a Health Care Provider representing Union Pacific to contact my Health Care Provider, if necessary, for purposes of clarification and authenticity of the medical certification. Both I and/or my family member certify that this request is truthful and accurate to the best of our knowledge.

Employee's Signature _____ Date _____

Family Member's Signature _____ Date _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Patient's Name:							
Relationship to Employee:	If patient is employee's child - age:						
<p>1. Does the patient's condition qualify as a "serious health condition?" (Definitions of a serious health condition are located on page 3)</p> <p><input type="checkbox"/> No. Does not have a "serious health condition"</p> <p><input type="checkbox"/> Yes has a "serious health condition", (check the category or categories the patient's condition qualifies under)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> 1. Hospital Care</td> <td><input type="checkbox"/> 4. Chronic Conditions Requiring Treatment</td> </tr> <tr> <td><input type="checkbox"/> 2. Absence Plus Treatment</td> <td><input type="checkbox"/> 5. Permanent/Long Term Incapacity</td> </tr> <tr> <td><input type="checkbox"/> 3. Pregnancy (EDC: _____)</td> <td><input type="checkbox"/> 6. Multiple Treatments</td> </tr> </table>		<input type="checkbox"/> 1. Hospital Care	<input type="checkbox"/> 4. Chronic Conditions Requiring Treatment	<input type="checkbox"/> 2. Absence Plus Treatment	<input type="checkbox"/> 5. Permanent/Long Term Incapacity	<input type="checkbox"/> 3. Pregnancy (EDC: _____)	<input type="checkbox"/> 6. Multiple Treatments
<input type="checkbox"/> 1. Hospital Care	<input type="checkbox"/> 4. Chronic Conditions Requiring Treatment						
<input type="checkbox"/> 2. Absence Plus Treatment	<input type="checkbox"/> 5. Permanent/Long Term Incapacity						
<input type="checkbox"/> 3. Pregnancy (EDC: _____)	<input type="checkbox"/> 6. Multiple Treatments						
2. Describe the medical facts which support the certification of the <u>patient's</u> serious health condition as defined by the categories above:							
3. Does the <u>patient</u> experience incapacity due to the serious health condition such as the inability to work or perform the essential functions of their job, attend school or daycare, and/or perform regular daily activities? Yes No							
4. Condition or Need for Care requires <u>employee</u> to take: <input type="checkbox"/> Block Leave <input type="checkbox"/> Intermittent Leave or <input type="checkbox"/> Reduced Work Schedule <i>If leave is to be taken intermittently or on a reduced work schedule, explain the medical necessity of such leave:</i>							
5. Date the Incapacity Commenced:							
6. Probable duration of Incapacity:							
7. Inpatient Care - Admission date:	Release/Estimated Release Date:						
8. If the condition is a chronic condition, the frequency and duration of episodes of incapacity are likely to occur: _____ <input type="checkbox"/> hours or <input type="checkbox"/> days ; every _____ <input type="checkbox"/> week(s) <input type="checkbox"/> month(s) or <input type="checkbox"/> year, based on the patient's medical history and current health status.							

CERTIFICATION OF HEALTH CARE PROVIDER Cont. (Family and Medical Leave Act of 1993)

9. Did the patient have an office visit? Yes No Date of visit:

Scheduled or expected follow up visit(s):

10. If treatment is required for the condition, **describe** the Treatment Plan (e.g., prescription drugs or therapy including treatment provided by another Health Care Provider):

- (10) a. Date the treatment began: _____
 b. The prescribed duration of treatment: _____
 c. The estimated number of treatments: _____
 d. The Approximate interval of treatments: _____
 e. Recovery period due to treatment required: _____

11. Is it necessary for the employee to be absent from work to attend treatments? Yes No

12. Describe the patient's **"Need For Care"**

- Is the family member unable to care for his/her own **basic medical** or personal needs such as **nutrition** or **hygiene**? Yes No
Explain:
- Does the family member require assistance with **safety**? Yes No
Explain:
- Is the family member **unable to transport him/her self** to the health care provider? Yes No
Explain:
- If the family member is receiving **inpatient or in home care**, is the employee needed to provide psychological care and comfort to the family member? Not applicable Yes No
Explain:

13. What is the probable amount of time required providing care as described in question 12?

HEALTH CARE PROVIDER INFORMATION

Name (please print):

Type of Practice:

Clinic / Hospital:

Area Code and Phone Number:

Address

Fax Number:

City:

State:

Zip Code:

Signature:

Date:

A "**Serious Health Condition**" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (*i.e.*, an overnight stay) 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.

2. Absence Plus Treatment

(a) 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** 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 (*e.g.*, 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 the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care**

4. 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 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 incapacity² (*e.g.*, asthma, diabetes, epilepsy, etc.).

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 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, a severe stroke, other terminal stages of a disease.

6. 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), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

* "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor or recovery therefrom.

** Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

***A regimen of continuing treatment includes, for example, a course of prescription medication (*e.g.*, an antibiotic) 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

Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room 5-3502, 200 Constitution Avenue, N. W., Washington, D.C. 20210.