



MIT MEDICAL CERTIFICATION FOR FMLA LEAVE

1. Employee Information

Employee's Name: _____ Employee's MIT #: _____

Extension: _____ Department: _____

2. Leave Request To Care For A Family Member

Patient Name: _____

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

TO BE COMPLETED BY HEALTHCARE PROVIDER

3. Serious Health Condition

Page 3 describes what is meant by a "**serious health condition**" under the Family Medical Leave Act. Does the patient's condition¹ qualify under any of the categories described? If so, please check all applicable categories.

1. Hospital Care <input type="checkbox"/>	2. Absence Plus Treatment <input type="checkbox"/>	3. Chronic Conditions Requiring Treatments <input type="checkbox"/>	4. Pregnancy <input type="checkbox"/>
5. Permanent/Long Term Conditions Requiring Supervision <input type="checkbox"/>		6. Multiple Treatments (Non-chronic Conditions) <input type="checkbox"/>	7. None of the above <input type="checkbox"/>

4. Medical Facts

Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5. Dates

1. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**² if different):
2. Will it be necessary for the employee to take only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?

If yes, give probable duration: _____

3. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated² and the likely duration and frequency of **episodes of incapacity**²:

6. Treatments

1. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any.
2. If any of these treatments will be provided by **another provider of health service** (e.g., physical therapist), please state the nature of the treatments:
3. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. Ability To Perform Work

1. If medical leave is required for the employee's **absence from work** because of the **employee's own health condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?
2. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:
3. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

8. Care Assistance

1. If leave is required to **care for a family member** of the employee with a serious health condition, does the patient require **assistance** for basic medical or personal needs or safety, or for transportation?
2. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?
3. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider

(Print Name)

Date

Type of Practice

Telephone

Address

Employee Signature

Date

=====
Definitions of Serious Health Condition

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 incapacity² or subsequent treatment in connection with or consequent to such inpatient care.
2. Absence Plus Treatment
A period of incapacity² of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:
 1. **Treatment³ 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 treatment⁴** under the supervision of the health care provider.
3. Pregnancy
Any period of incapacity due to **pregnancy, or 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 **Incapacity²** 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, or the terminal stages of a disease.
6. Multiple Treatments (Non-Chronic Conditions)
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 on a 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 Incapacity² 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).

¹ Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

² "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 therefore or recovery there from.

³Treatment 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.

⁴A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., 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; bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Return forms to:
MIT Disability Office
77 Massachusetts Avenue, Bldg. E19-215
Cambridge, MA 02140
Phone: 617-253-6151
Confidential Fax: 617-253-1502