SAMPLE FORM EMPLOYEE MIGRAINE

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 INFO	RMATION	
Employee's Name: Your N	Vame Here	
EIN:	FMLA (Case #
II. <u>CONDITION REQU</u>	JIRING LEAVE	
		ndition the Employee has. See page health condition" for purposes of
1. Hospital Care	3. Pregnancy	5. Permanent Long-term
and bed rest prescribed as a r		an intermittent basis. Rx medications
III. DURATION AND E	XTENT OF LEAVE REQUI	IRED
What is the date the condition	a commenced?August	3,1997
On which dates did you treat	the Employee in the past 12 m	onths? <u>1/3/15, 3/20/2015, 11/20/15</u>
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How long do you project the condition to continue? <u>Lifetime to be reviewed annually</u>		
How long will the Employee be incapacitated (if different)? 1-3 days		
How long will the Employee need to be on leave because of the condition?		
Lifetime to be reviewed annually		
Vill the Employee need treatment at least twice per year for the condition? X Yes1		
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)? X Yes No		
If yes, please provide the following additional information:		
Estimated dates of scheduled treatment: <u>1 scheduled visit every 3 months for monitoring of medications</u>		
Frequency of treatment/episodes of incapacity: <u>1-3</u> times perweek <u>1</u> month		
Duration of treatment/episode of incapacity:hour(s) or _1-3 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 the Employee's position without physical restrictions, accommodations or modification of job duties?X_YesNo		
If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? YesNo		
If yes, describe the physical restrictions, accommodations or modification of job duties required:		
Employee Migraine		
IV. <u>HEALTH CARE PROVIDER SIGNATURE</u>		
Signature: <u>Dr. Jane Brody</u> Date: <u>11/20/2015</u>		
Health Care Provider's Name (Please print): _Dr. Jane Brody		
Address: _557 Roman Dr. Atlanta GA		
Telephone Number:Fax Number:		
Specialty/Type of Practice: Neurology		