SAMPLE FORM EMPLOYEE PREGNANCY

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 INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care** _X_ 3. **Pregnancy** __ 5. **Permanent Long-term Condition**

__ 2. **Absence Plus Treatment** __ 4. **Chronic Condition** __ 6. **Multiple Treatments** (Non-Chronic Condition)

Describe the medical facts and/or treatment that meet the criteria of the serious health condition checked above. This may include symptoms; nature of the condition; dates of treatment; or any regimen of continuing treatment such as a course of prescription medication or therapy requiring use of specialized medical equipment. ***Medical diagnosis/prognosis is not required.*** **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

Patient is pregnant and requires intermittent prenatal care, and may be intermittently incapacitated due to nausea, vomiting, pain and fatigue.

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? January 5, 2015 (approx.)

On which dates did you treat the Employee in the past 12 months? 2/3/2015, 3/5/2015

How long do you project the condition to continue? 7-8 months

How long will the Employee be incapacitated (if different)? Intermittently throughout pregnancy, and 6-8 weeks after delivery

How long will the Employee need to be on leave because of the condition? Up to 2 times per week lasting 1-3 days per episode throughout pregnancy, and 6-8 weeks after delivery

Will the Employee need treatment at least twice per year for the condition? _X_ Yes ___ No

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: prenatal visits 1 time per month for 6 months; visits will increase to 2-3 visits per month in last 3 months of pregnancy.

Frequency of treatment/episodes of incapacity: _2_ times per _1_ week ___ 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: 1-3 day per episode for periodic incapacitation during pregnancy; recovery after pregnancy expected to last 6-8 weeks

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? __ Yes __X_No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? __X_ Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required: Employee restricted from lifting more than 10 pounds during pregnancy *[adjust as necessary or delete if it does not apply]*

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *Dr. Saul Shapiro* Date: March 5, 2015

Health Care Provider's Name (Please print): Dr. Saul Shapiro

Address: 9585 Baylor Ave. Brighton Beach NY

Telephone Number: _____ Fax Number: _____

Specialty/Type of Practice: OB/GYN