SAMPLE FORM SPOUSE PERMANENT LONG TERM

CERTIFICATION OF FAMILY MEMBER'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 # _____

Name of Patient: _____

Relationship of Employee to patient for whom leave is requested: spouse
(Spouse, Parent, Child; child over 18 must be incapable of self-care because of disability)

II. CONDITION REQUIRING LEAVE

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

Sample Spouse Permanent Long Term Care

__ 1. **Hospital Care** ___ 3. **Pregnancy** _X_ 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.

The employee's spouse suffers from a liver disorder/disease that requires medical treatment and long-term care. The treatment prescribed causes a number of side effects that render the spouse

incapable of self-care. Side effects include fatigue, anemia, nausea, diarrhea, depression, headaches and flu-like symptoms.

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? Feb 18, 2008

On which dates did you treat the patient in the past 12 months? 4/19/2015, 5/21/2015

How long do you project the condition to continue? Lifetime to be review annually

How long will the patient be incapacitated (if different)? 3 to 6 months

Does the patient require assistance to meet basic medical, hygiene, nutritional, safety or transportation needs because of the condition or during periods of incapacity? _X_ Yes ___ No

If not, would the Employee's presence provide psychological comfort beneficial to the patient's recovery? _X_ Yes ___ No

How long will the Employee need to be on leave to care for the patient? 3 to 6 months

Will the patient 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 of the patient (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of the patient's incapacity (for example, flare ups)? _X_ Yes __No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _7/3/15, 8/4/15, 9/5/15, 10/4/15

Frequency of treatment/episodes of incapacity: _1-4_ times per _week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _1-4 day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: _1 to 4 days after each treatment.

Sample
Spouse Permanent Long Term Care

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *Dr. Joan Miller* Date: 6/26/15

Health Care Provider's Name (Please print): Dr. Joan Miller

Address: 574 Maple Ave Huntington WV

Telephone Number: _____ Fax Number: _____

Specialty/Type of Practice: Internal Medicine