GOVERNMENT OF THE DISTRICT OF COLUMBIA
D.C. Department of Human Resources

Medical Certification by Health Care Provider **D.C. Family and Medical Leave Act of 1990**

(When completed, this form goes to the employee)

1. Employee's Name	2. Patient's Name (if different from employee)

3. Page 4 describes what is meant by a **"serious health condition"** under the D.C. Family and Medical Leave Act of 1990. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____, or None of the above _____

4. 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. a. 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):

b. Will it be necessary for the employee to take work 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 the probable duration:

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

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

[2] For the purposes of family or medical leave the term "incapacity" is defined to mean the inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore or recovery therefrom.

6. a. 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:

b. If any of these treatments will be provided by **another provider of health services** (*e.g.*, physical therapist), please state the nature of the treatments:

c. 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. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?

b. If able to perform some work, is the employee **unable to perform any one (1) 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:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

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8. a. 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?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

c. 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

Type of Practice

Address

Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:

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:

Employee Signature

Date

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

1. **Inpatient Care** – in a hospital, hospice, or residential health care facility (*e.g*., an overnight stay).

2. **Continuing Treatment** Required by a Health Care Provider[3] (e.g., physical therapy)

3. **Pregnancy** (*e.g*., ongoing pregnancy, miscarriages, complications or illnesses related to pregnancy, prenatal care, childbirth, recovery from childbirth).

4. **Chronic Conditions** Requiring Treatments by a Health Care Provider (*e.g*., asthma, diabetes, epilepsy).

5. **Permanent/Long-term Conditions** Requiring Supervision by a Health Care Provider (*e.g*., Alzheimer's, a severe stroke, terminal stages of a disease)

6. **Multiple Treatments (Non-Chronic Conditions)** Required by a Health Care Provider (*e.g*., chemotherapy, radiation, 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 (2nd) or third (3rd) opinions and recertification.

[COMPLETED FORM GOES TO THE EMPLOYEE]

[3] 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.