MARANA AZ
HUMAN RESOURCES

CERTIFICATION OF HEALTH CARE PROVIDER

1. **Employee's Name**: _____ **Date:** _____

2. **Patient's Name** (if different from employee):_____

3. Does the patient's condition qualify under any of the categories described in the "serious health condition section? *(See attached sheet for more information on Serious Health Condition definitions).* If so, please check the applicable category:

1. ☐ Hospital care
2. ☐ Absence plus treatment
3. ☐ Pregnancy
4. ☐ Chronic conditions requiring treatment
5. ☐ Permanent/Long-term conditions requiring supervision
6. ☐ Multiple treatments (nonchronic conditions)

4. Describe the <u>medical facts</u> that support your certification, including a brief statement on how the Medical facts meet the criteria of one of thes categories:

5(a). State the approximate date the condition commenced and its probable duration (and also probable <u>duration</u> of the patient's present <u>incapacity</u> if different):

(b). Will it be necessary for the employee to work only intermittently or on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)?

☐ Yes ☐ No If yes, give the probable duration:

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

Mail the original to: Town of Marana HR Dept. 11555 W. Civic Center Drive Marana, AZ 85653
Please fax a copy to FAX: 520-382-3500 ATTN: Benefits
Any questions, please contact our HR Office at 520-382-1922 or 382-1925

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?

☐ Yes ☐ No

(b). If able to perform some work, is the employee unable to perform at least one of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job function)?

☐ Yes ☐ No

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?

☐ Yes ☐ No

If yes, please explain why:

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, safety or transportation?

☐ Yes ☐ No

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

☐ Yes ☐ No

(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)

_____ _____
(Date) (Address)

_____
(Telephone Number)

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)

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., overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with, or as a consequence of, such as inpatient care.

2. **Absence Plus Treatment**
A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition that also involves:
(1) Treatment two or more times by a health care provider, nurse, or a 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 that results in a regimen of continuing treatment[4] under the supervision of the health care provider.

3. **Pregnancy**
Any period of incapacity due to pregnancy or for prenatal care.

4. **Chronic Conditions Requiring Treatments**
A chronic condition that:
(1) Requires periodic visits for treatment by a health care provider or nurse or physician's assistant under the 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 incapacity rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy; etc.)

5. **Permanent/Long-term Conditions Requiring Supervision**
A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's a sever stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Nonchronic Conditions)**
Any period of absence to receive multiple treatments (including any period of recovery from them) by a health care provider or a provider of health care services under orders of, or on 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 incapacity[2] 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), or kidney disease (dialysis).