Family and Medical Leave Act (FMLA)

The FMLA provisions are outlined in the FOP 88 and State of Nebraska Labor Contract, NAPE/AFSCME and State of Nebraska Labor Contract, the SLEBC and State of Nebraska Labor Contract, the Classified System Personnel Rules and Regulations, and federal statutes and regulations. Listed below are some highlights of these sections.

FMLA leave is unpaid time off from work. An employee can use paid vacation leave, compensatory time, or sick leave (see valid reasons for using sick leave in Section 14.11 of the FOP 88 and State of Nebraska Labor Contract, NAPE/AFSCME Labor Contract, Section 11.3.1 of the SLEBC labor contract, and Chapter 10, Section 005.001 of the Classified System Personnel Rules and Regulations), as part of their 12 weeks of FMLA Leave, if the employee should so choose. An employee must have at least twelve total months of service and at least 1250 hours (actual work hours) of service in the previous twelve month period to be eligible for FMLA Leave. Leaves and observed holiday time do not count toward the 1250 hours, only time worked counts. Temporary employment with the State of Nebraska counts toward an employee's eligibility.

Requests for sick leave should be approved/denied based upon your agency's application of the sick leave provisions contained in the applicable labor contracts and the Rules. The FMLA does not change the way the State administers sick leave. An employee may receive approval in advance for the intermittent use of FMLA. Approval of employee requests for vacation leave during periods of unpaid FMLA in order to receive pay for a holiday which occurs during an unpaid FMLA is not recommended but is allowed. A minimum of 30 days notice to the Agency must be provided by the employee before he/she may use FMLA Leave. Where 30 days notice is not foreseeable, notice must be given as early as possible.

Leave Entitlement.
A covered employer must grant an eligible employee up to a total of **12 workweeks** of **unpaid** leave during any 12-month period for one or more of the following reasons:

- for the birth and care of a newborn child of the employee;
- for placement with the employee of a son or daughter for adoption or foster care;
- to care for a spouse, son, daughter, or parent with a serious health condition;
- to take medical leave when the employee is unable to work because of a serious health condition;
- for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the Armed Forces, National Guard or Reserves in support of a contingency operation in a foreign country;
- A covered employer also must grant an eligible employee who is a spouse, son, daughter, parent, or next of kin of a current member of the Armed Forces, National Guard or Reserves; next of kin of a member who left the Armed Forces, National Guard or Reserves less than five years ago; with a serious injury or illness up to a total of **26 workweeks** of **unpaid** leave during a "single 12-month period" to care for the service member.

Spouses employed by the same employer are limited in the **amount of** FMLA leave they may take for the birth and care of a newborn child, placement of a child for adoption or foster care, or to care for a parent who has a serious health condition, to a combined total of 12 weeks (or 26 weeks if leave to care for a covered service member with a serious injury or illness is also used). Leave for birth and care, or placement for adoption or foster care, must conclude within 12 months of the birth or placement.

Under some circumstances, employees may take FMLA leave intermittently – taking leave in separate blocks of time for a single qualifying reason – or on a reduced leave schedule – reducing the employee's usual weekly or daily work schedule. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operation. If FMLA leave is for birth and care, or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.

Under certain conditions, employees **or** employers may choose to "substitute" (run concurrently) accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave. An employee's ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

"Serious health condition" means an illness, injury, impairment, or physical or mental condition that involves either:

- Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (*i.e.*, inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or**

- Continuing treatment by a health care provider, this includes:

  (1) A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition that **also** includes:

    - treatment two or more times by or under the supervision of a health care provider (*i.e.*, in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or**

    - one treatment by a health care provider (*i.e.*, an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (*e.g.*, prescription medication, physical therapy); **or**

  (2) Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; **or**

  (3) Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; **or**

  (4) A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment; **or**

  (5) Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

In the case of a member of the Armed Forces, including the National Guard and Reserves- A **"serious injury or illness"** is one that occurs in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank or rating [29 U.S.C. § 2611(18)], and in the case of a veteran, one that was incurred in the line of duty on active duty that manifested itself before or after the member became a veteran.

Health Insurance while on FMLA Leave. Employer health insurance contributions shall continue during an employee's unpaid FMLA Leave absence, provided the employee makes his/her required contribution and intends to return to work for at least 30 days following his/her FMLA leave except as specified below. Employer contributions shall be based as if the employee had continued to work his/her normal schedule. When an employee does not return from FMLA Leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle the employee to FMLA Leave; or, 2) other circumstances beyond the employee's control, the employee will be required to reimburse the State for the State's share of health insurance premiums paid on the employee's behalf during the FMLA Leave. Personnel Contacts should continue to coordinate questions regarding health insurance with the AS-Employee Benefits Section, (402) 471-4443.

Effect of Leave on Bonuses. Employers may disqualify employees from bonuses or other achievement payments based on job related performance goals, such as attendance or products sold, when the employee has not met the goal because they took FMLA leave, as long as the same rules apply to employees on other types of leave.

Employers Can Directly Contact the Employee's Doctor. An employer's HR administrator, leave administrator, or management official (but not the direct supervisor) may directly contact an employee's health care provider to clarify and authenticate the certification after giving the employee an opportunity to cure any deficiencies in the medical certification.

Recertification. If an employee is taking leave intermittently or is on a reduced work schedule, an employer can't require recertification before the end of the minimum period of the initial certification. The Federal Regulations at §825.308, in summary, state:

> If the minimum duration of the period of incapacity specified on a certification furnished by the health care provider is more than 30 days, the employer may not request recertification until that minimum duration has passed. For FMLA taken intermittently or on a reduced leave schedule basis, the employer may not request recertification in less than the minimum period specified on the certification as necessary for such leave (including treatment) unless one of the conditions set forth in paragraph (c) (1), (2) or (3) of Section 825.308 of the Federal Regulations is met.
>
> The exceptions listed in (c) (1), (2) or (3) include when:
>
> (1) The employee requests an extension of leave;
>
> (2) Circumstances described by the previous certification have changed significantly (e.g., the duration of the illness, the nature of the illness, complications); or
>
> (3) The employer receives information that casts doubt upon the continuing validity of the certification.

If you have any questions on the Family and Medical Leave Act, please contact Employee Relations at (402) 471-4106, (402) 471-8292, or (402) 471-4104.

Family and Medical Leave Request Form
(Family and Medical Leave Act)

State of Nebraska

Employee Name: _____

Agency: _____

1. I have at least twelve months service with the State of Nebraska. **YES** **NO**
   Note: *Service may be with more than one Agency -- service need not be continuous.*

2. I have been paid for at least 1,250 hours of work by the State of Nebraska in the past twelve months. (Does not include leave hours) **YES** **NO**

Go forward only if all previous Questions have been answered YES and you have not used more than twelve weeks of FMLA Leave in the past twelve months.

3. Reason for FMLA Leave:

Note: *FMLA Leave under the following circumstances must be completed no later than one year after the child's birth, adoption, or foster care placement.*

☐ I am the mother or father of a newborn child. The child's birthdate or expected birthdate is _____.

☐ I am adopting or have legally adopted a child. The date of child's placement in my home was/is _____.

☐ Placement of a foster child in my home. The date of child's placement in my home was/is _____.

☐ Personal request due to exigencies arising out of the fact my spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard, Reserves, or regular duty Armed Forces personnel who are deployed to a foreign country, in support of a contingency operation.

Note: *In each case below, a serious health condition is defined as requiring one of the following: (1) inpatient care, (i.e. an overnight stay); (2) a period of incapacity of more than three consecutive calendar days, and treatment two or more times by a health care provider, or treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider; (3) incapacity due to pregnancy or prenatal condition (4) a chronic condition requiring at least two visits per year for treatment by a health care provider; or (5) a permanent/long-term condition requiring supervision This does not include voluntary or cosmetic treatments unless inpatient hospital care is required.*

Note: *In each case below, a* ***Health Care Provider's Certification Form*** *must be completed and returned within 15 calendar days of submission of this form.*

☐ Care for my seriously ill mother or father. *(if not your biological or adoptive parent, you must present satisfactory evidence of parental relationship -- care for a mother-in-law or father-in-law does not qualify for FMLA Leave)*

☐ Care for my seriously ill spouse. *(must be legal spouse; unmarried domestic partners do not qualify for FMLA Leave)*

☐ Care for my seriously ill child. *(If not your biological, adoptive, foster, or step-child, you must present documentation of parent-child relationship)*

☐ Personal request due to my serious health condition or injury *(would include recovery from childbirth or extended pre-natal care).*

*Note: In the cases below, a **Serious Injury or Illness of a Current Service Member Certification Form** or **a Serious Injury or Illness of a Veteran for Military Caregiver Leave Certification Form** must be completed and returned within 15 calendar days of submission of this form.*

☐ I am the next of kin of a current service member who has a serious illness or injury incurred in the line of duty, while on active duty.
☐ I am the next of kin of a Veteran who has a serious illness or injury that was incurred or aggravated when the covered veteran was a member of the Armed Forces.

4. I understand that FMLA Leave is strictly unpaid leave that is used at the employee's discretion for qualifying events. Accrued paid leave may be used as part of the 12 weeks, under the conditions noted previously, at the employee's discretion.

5. I understand that in cases where FMLA Leave is foreseeable, I must apply, for FMLA Leave a minimum of 30 days in advance. In cases where FMLA Leave is not foreseeable, I understand it is my responsibility to apply for FMLA Leave as early as possible and practicable, either before or after the FMLA Leave event.

***Note:** In all circumstances, employees are required to complete this form.*

6. My first day of absence from work will be _____, and I will return to work on _____. If exact dates are unknown, please enter approximate dates.

***Note:** Total absence may not exceed twelve weeks or twenty-six weeks for service member caregiver leave. In cases of childbirth, adoption, or foster child placement, the employer may require the leave to be taken in a single continuous period. In cases of serious health condition, leave may be taken intermittently for medical reasons, according to a schedule approved by the health care provider (attach leave schedule to the Health Care Provider's Certification Form).*

7. I understand that FMLA Leave is strictly unpaid leave. Requests for sick and vacation leave and/or compensatory time will be processed according to applicable labor contracts or Personnel Rules. Use of sick leave, vacation leave and compensatory time **may** be counted towards my twelve weeks of FMLA Leave.

8. I understand that sick and vacation leave will not accrue and holidays will not be compensated during non-paid absences.

9. I understand that my service date will be adjusted if my unpaid absence exceeds fourteen consecutive calendar days.

10. I understand that I must complete the ***Insurance Coverage Continuation Form***.

11. I understand that if the absence from work was due to my personal health condition, I must submit a "Release for Duty" report from my Health Care Provider prior to my return to work.

12. I understand that when I return to work, I will be returned to the same job I left or an equivalent job and that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing.

Employee Signature: _____ Date: _____

☐ ***Approved***

☐ ***Denied*** (employee requests may not be denied without prior notification to AS-Employee Relations Division)

Agency Authorized Signature: _____ Date:_____

If you need help using this form, please contact your agency Personnel Office or AS Employee Relations at (402) 471-8292 - TDD (402) 471-4693

Insurance Coverage Continuation Form *(during Family and Medical Leave)*

Name: _____ S.S.# _____ Empl. ID: _____ Date of Leave: _____

Current Coverage:	***Continue?*** **YES / NO**		Option or Type	Premium Employer	Premium Employee
*Health	_____	_____	_____	_____	_____
Dental	_____	_____	_____	_____	_____
Life	_____	_____	_____	_____	_____
Vision	_____	_____	_____	_____	_____
Flexible Spending Accounts	_____	_____	_____	_____	_____
Long Term Disability	_____	_____	_____	_____	_____

Employee's Total: _____

Circle one: Bi-Weekly /Monthly /Other

1. *I understand that my Agency will continue to pay for the State's contribution of my health coverage during my absence. I understand my Agency's obligation to continue to contribute to my health coverage ends when:

a. I choose not to retain health coverage during my FMLA Leave absence as I have indicated above; or

b. I fail to return from leave upon schedule, or I inform my Agency of my intent not to return.

(Upon separation from employment, COBRA insurance continuation provisions may apply.)

2. I understand that if I choose to continue my insurance as indicated above, my premium is due by the first of the month for the month of coverage (check made out for the above specified total to the Department of Administrative Services, and delivered to my Agency's Personnel Officer). If my premium is not remitted by the first calendar day of the month, my coverage will be suspended until my payment is received. If my payment is not received by the last calendar day of the month, my coverage will be terminated permanently until my return to work.

3. I understand that while on leave, I will have the same opportunities as other employees to change coverage, plans or benefits (open enrollment opportunities, for example).

4. I understand the State may recover the State contributions made on my behalf should I fail to return to work after my FMLA Leave entitlement expires, unless the reason I fail to return is due to:

(a) a continuation, recurrence, or onset of a serious health condition which would entitle me to leave under the Family and Medical Leave Act; or

(b) other circumstances beyond my control as defined in the Family and Medical Leave Act.

Employee Signature: _____ Date: _____

If you need help using this form, please contact your agency Personnel Office or AS-Employee Benefits at (402) 471-4443. Revision 4/11

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: Nebraska Department of Transportation Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*, I am able to work _____ *(hours per day)* _____ *(days per week)*.

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (____) _____ Fax: (____) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient *(e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)*.

_____

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery

_____ *(e.g. 3 days/week)*

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.