

Family and Medical Leave

GEORGIA DEPARTMENT OF HUMAN RESOURCES
CERTIFICATION OF SERIOUS HEALTH CONDITION

TO BE COMPLETED BY HEALTH CARE PROVIDER:

| | |
|------------------|---|
| Employee's Name: | Patient's Name and Relationship to Employee (if different from employee): |
|------------------|---|

Page 3 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition¹ qualify under any of the categories described? If so, please check the applicable category.

- (1) Hospital Care
- (2) Absence plus Treatment
- (3) Pregnancy
- (4) Chronic Conditions Requiring Treatments
- (5) Permanent / Long-term Conditions Requiring Supervision
- (6) Multiple Treatments (Non-Chronic Conditions)
- (7) None of the above

Complete this section for the serious health condition of the employee.

Describe the **medical facts** that support the employee's need to be absent from work due to a serious health condition.

Approximate date condition began: _____ Expected duration of condition: _____

Describe the regimen of treatment prescribed (including number of visits, general nature and duration of treatment, referral to other health service providers, etc.)

Is inpatient hospitalization required? Yes No

Is the employee able to perform work of any kind? Yes No

Is the employee able to perform essential job functions, with or without reasonable accommodation? Yes No

If yes, please describe recommended accommodation, if any:

If the employee is able to perform some or all essential job functions, will it be necessary for the employee to be absent from work on an intermittent basis (e.g., to attend weekly therapy appointments) or to work less than a full work week (e.g., to work 20 hours per week rather than 40 hours?) Yes No

If yes, please describe:

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

Family and Medical Leave

Complete this section for the serious health condition of an employee's family member.

Please indicate the dates for which the employee's presence is necessary to care for a family member with a serious health condition:

From: _____ To: _____

Describe the **medical facts** that support the employee's need to be absent from work to care for a family member with a serious health condition, including care for basic medical or personal needs and/or psychological comfort.

Will it be necessary for the employee to be off work on an intermittent basis or to work less than the normal work schedule to care for the family member? Yes No

If yes, please describe:

Additional Comments:

Signature of Health Care Provider

Date

Address

Type of Practice

Telephone Number

Note: It is the employee's responsibility to ensure that this form is fully completed.

Family and Medical Leave

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

2. Absence plus Treatment

(a) 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) **Treatment² two or more times** by a health care provider, by a nurse or 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** which results in a **regimen of continuing treatment³** 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** which:

- (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician’s assistant under 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** rather than a continuing period of incapacity (*e.g.*, asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision

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

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by 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 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), and kidney disease (dialysis).

² 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.

³ 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; nor does it include bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

FAMILY LEAVE
RESPONSE TO APPEAL

To:

Date:

From: Executive Director
McIntosh Trail Community Service Board
1501-A Kalamazoo Drive (P. O. Box 1320)
Griffin, Georgia 30224

I have reviewed your appeal of the denial of your application for Family Leave. My decision and the reason(s) for the decision is indicated below:

You have the right to appeal this decision to the Commissioner of Personnel Administration. Your appeal must be filed with me within three (3) work days of your receipt of this decision. Upon receipt of your request, I will immediately forward your appeal to the Merit System. If you fail to file an appeal within three (3) work days, you will forfeit any further right of appeal.

Signature _____

Title _____

FAMILY LEAVE

Appeal to the Commissioner of Personnel Administration

Date:

To:

Address:

From:

Address:

Social Security Number:

My application for Family Leave has been denied by my supervisor and my appeal of that decision has been denied by the reviewing official of my agency. As authorized by State Personnel Board Rule 23, Par.23.703.B, I request that my appeal be forwarded to the Commissioner of Personnel Administration at the State Merit System. I understand that the decision of the Commissioner of Personnel Administration is final and binding upon me and my agency.

Signature _____