OFFICE OF THE DEFENDER GENERAL
STATE OF VERMONT
Certification of Health Care Provider - Employee

This form is to be completed when the family leave is needed for an EMPLOYEE'S own "serious illness."

Employee's Name: _____ Department: _____

Release of Medical Information: I authorize the release of any medical information necessary to provide the information requested on this form.

Employee Signature:_____Date:_____

SERIOUS HEALTH CONDITION:

1. Form PERFMLA 5 describes what is meant by a **"serious health condition"**[1] under the State and Federal Family and Medical Leave Acts. Does the **employee's condition** 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: Please specify why the leave is required

Date Condition Began: _____
Date Condition Expected to End: _____

2. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one or more of these categories:

TREATMENTS:

3. Will the employee be absent from work or other daily activities on an **intermittent** or **reduced schedule** basis because of **treatment?**

_____Yes
_____No
If Yes: Number of treatments: _____
Interval between treatments:_____
Dates of treatments:_____
Period of recovery:_____

4. 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:

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

5. If a **regimen of continuing treatment** by the employee is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

INCAPACITY:

6. Is the employee **presently incapacitated[2]?**
   _____Yes
   _____No
   If yes, give the probable duration:_____

7. If the condition is a **chronic condition** or **pregnancy**, are **episodes of incapacity likely**?
   _____Yes
   _____No
   If yes, give the probable duration of episodes:_____
   If yes, give the probable frequency of episodes:_____

8. Would an **intermittent or reduced schedule** be constant with the employee's condition?
   _____Yes
   _____No
   If yes, give the probable duration:_____

Note: Employee is advised to refer to the **Employee Request** form (PERFMLA 1) for information regarding intermittent or reduced leave schedules because these schedules may affect an employee's leave accrual and other benefits.

ABILITY TO WORK:

9. Is the employee **able to perform** work of any kind?
   _____Yes
   _____No

10. If able to perform some work, is the employee **unable to perform any one 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)?
    _____Yes
    _____No
    If yes, please list the essential functions the employee is unable to perform:

11. If neither 9 nor 10 applies, is it necessary for the employee to be **absent from work for treatment?**
    _____Yes
    _____No
    If yes, please explain?

Signature of Physician or Health Care Provider: _____Date: _____

_____
(Address) (Telephone Number)

Type of Practice or Specialization: _____

NOTE: ALL DOCUMENTATION RELATED TO FAMILY LEAVE MUST BE FORWARDED TO YOUR DEPARTMENT'S HUMAN RESOURCES SECTION FOR RECORD KEEPING. WRITTEN INFORMATION RELATED TO FAMILY LEAVE IS CONSIDERED CONFIDENTIAL AND IS KEPT IN A MEDICAL FILE IN YOUR DEPARTMENT'S PERSONNEL UNIT.

[2] Incapacity, for purposes of FMLA, is defined to mean the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.