



## CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993 – Form WH-380)

1. Employee's Name:

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

3. Attached you will find a sheet which describes what is meant by a "serious health condition" under the Family and Medical Leave Act of 1993.

Does the patient's condition qualify under any of the categories described?  Yes  No

4. If yes, indicate the applicable category:  1  2  3  4  5  6

5. Describe below the medical facts which support your certification:

6. State the approximate date the condition commenced:

7. State the probable duration of the condition/incapacity - From: \_\_\_\_\_ To: \_\_\_\_\_

8. Will it be necessary for the employee to work on an intermittent or less than full time basis?  Yes  No

9. If yes, state the probable duration of need for a reduced schedule or intermittent leave:

10. If the condition is a chronic condition (#4) or pregnancy (#3), state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

11. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

12. If the patient will be absent from work or other daily activities because of treatment on an intermittent or reduced scheduled leave, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment and period required for recovery:

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

14. If a regimen of continuing treatment is required for the patient, provide a general description of such regimen (prescription drugs, physical therapy, etc.):

15. a. If a medical leave is required for 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 any one or more of the essential functions of the employee's job (the employee or employer should provide you with the information about the essential job functions)?  Yes  No

16. If yes, list the essential functions the employee is unable to perform:

17. If neither (a) or (b) applies, is it necessary for the employee to be absent from work for treatment?  
 Yes  No

18. If leave is required to care for a family member with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?  Yes  No

19. 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

20. If the family member will need care only intermittently or on a part-time basis, indicate the probable duration of this need:

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Address of Health Care Provider

\_\_\_\_\_  
Telephone Number of Health Care Provider

**To be completed ONLY by the employee when needing 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