

STATE OF COLORADO Medical Certification Form

Instructions to Employee: If incomplete or illegible, this certificate will be returned to you for correction. Failure to provide this certificate will result in denial of sick leave and possible delay or denial of any applicable family/medical leave. Knowingly providing false information directly, or through another party, may result in corrective and/or disciplinary action.

Instructions to Employing Agency: For the employee's condition, attach the task statements from the official Position Description Questionnaire. Complete the "Completed Form Due" box. This completed form is to be placed in a separate, confidential medical file with limited access.

Instructions to Health Care Provider: Please provide information as it relates only to the current condition. Please complete in order to avoid potential adverse consequences for the employee.

Employee's Name:	Employee ID Number:
Patient's Name (if other than employee):	Completed Form Due:

1. The attached sheet describes "**serious health condition**" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories? Please check the category.

(1) ___ (2) ___ (3) ___ (4) ___ (5) ___ (6) ___, or None

2. Describe the **medical** facts regarding the condition, including a brief statement as to how these facts meet the category.

3. Date the condition began	Probable duration of condition	Probable duration of this absence
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4. (a) Are additional treatments necessary, including any that require the employee to work **intermittently** or on a **reduced** schedule? Yes No . If yes, give the following:

probable duration:

estimated # of treatments and period of recovery:

interval between treatments:

if treatment will be provided by **another provider of health services**, state the nature of treatments:

- (b) If the condition is a **chronic** condition or **pregnancy**, is the patient presently incapacitated? Yes No . What is the likely duration and frequency of episodes of incapacity?

(c) If a **regimen of continuing treatment** is required under your initiation and supervision, provide a general description (e.g., prescription drugs, physical therapy requiring special equipment).

5. (a) In the case of the employee's own condition, is the employee able to perform ***any*** work (see attached description of tasks from the employer)? Yes No .

(b) If able to perform ***some*** work, is the employee able to perform the essential functions (see attached description of tasks from the employer)? Yes No . If no, please list the essential function(s) the employee is unable to perform:

6. If leave is required for the serious health condition of a patient other than the employee, please explain the extent to which and length of time the employee is needed to provide care (e.g., basic medical assistance, personal needs, transportation, psychological comfort, etc.).

Based on my personal evaluation of the patient's condition, the above information is accurate and complete.

Health Care Provider Signature

Date

Printed Name

Type of Practice

Address

Phone

DEFINITIONS FOR MEDICAL CERTIFICATION FORM

Agency Instruction: To be attached, along with tasks statements from the official Position Description Questionnaire, to the Medical Certification Form.

“Serious Health Condition” is an illness, injury, impairment, or physical or mental condition that involves one of the following.

1. Inpatient 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 and recovery in connection with or consequent to such 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, by a nurse or physician's assistant under the direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under order 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 treatment** under the supervision of a health care provider.

3. Pregnancy.

Any period of incapacity due to **pregnancy**, including **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 the direct supervision of a health care provider; **AND**

(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 patient must be **under continuing supervision of, but need not be receiving active treatment by, a health care provider** (e.g., Alzheimer's, severe stroke, terminal stages of a disease).

6. Multiple Treatments (Non-Chronic Condition).

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), kidney disease (dialysis).

“Treatment” includes examinations to determine if a serious health condition exists and evaluations of the condition. It does not include routine examinations.

“Regimen of Continuing Treatment” includes, for example, a course of prescription medication (e.g., antibiotics) 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; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

“Incapacity” is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.