City of Missoula
FMLA Medical Certification

SECTION I: EMPLOYEE: PLEASE FILL OUT THIS SECTION, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER.

Printed Employee Name:	
Reason for leave:	
Patient Name (if other than employee):	Relation to employee:
Treating Physicians Name:	

SECTION II: HEALTH CARE PROVIDER: PLEASE FILL OUT THIS SECTION AND RETURN AS STATED BELOW.

Does the patient have a "serious health condition" ☐ Yes ☐ No (See definitions on page: 3 of Medical Certification)

If yes, please check reason:

☐ 1. Hospital stay
☐ 2. Incapacity plus treatment -- condition that causes more than three (3) days of incapacity and
  ☐ two or more treatments by a health care provider; or
  ☐ one treatment plus a continuing regimen under supervision of a health care provider
  Please request employee's job description if needed to determine "incapacity."
☐ 3. Pregnancy -- any period of incapacity due to pregnancy or prenatal care.
☐ 4. Chronic serious health condition
☐ 5. Permanent or long-term conditions -- requiring medical supervision
☐ 6. Multiple treatments for non-chronic condition

If the leave is to care for an *immediate family member*, is the employee's presence necessary and/or beneficial to the patient's care? ☐ Yes ☐ No

How long will the employee's presence be necessary to assist the family member?

Describe the medical facts that support your certification for which the patient is being treated:

State the approximate date the condition commenced and the probable duration of the condition:

Prescribed treatment (i.e., number of visits, nature and duration of treatment, etc.):

If any of these treatments will be provided by another provider of health services, please state the nature of the treatments:

Is intermittent leave or a reduced work schedule medically necessary? ☐ Yes ☐ No

If yes, describe:

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SECTION II: CONTINUED

Is the employee able to perform the essential functions of their position, at this time? ☐ Yes ☐ No
(We may provide and request your review of the employee's job description. Otherwise such information may be obtained from discussion with the employee)

Will the employee's work activities need to be modified upon return to work? ☐ Yes ☐ No

If so, tentative date employee may return to modified work?

Recommended modifications and duration?

Will any activities be limited permanently? ☐ Yes ☐ No

If yes, explain:

When is the anticipated return to work date with no limitations?

Comments:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Physician's Signature:		Date:
Health Care Provider's Address	Phone #	Fax #

PLEASE RETURN THIS FORM TO CITY OF MISSOULA – HUMAN RESOURCES DEPARTMENT:

FAX (preferred): 406-327-2151

E-mail: departmenth@ci.missoula.mt.us

Address: 435 Ryman St ATTN: Human Resources Missoula, MT 59802-4297

Phone: 406-552-6130

FMLA Medical Certification - Continued

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 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 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 treatment** 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 there from) 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).

Definitions:

"Incapacity," for purposes of FMLA, 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 there from.

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.

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; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.