

The State of Delaware FMLA Medical Certification



For Agency Use

- Approved
- Denied
- Require More Information
- Reviewed by:

1. Employee Name:
2. Patient Name (If other than employee):
3. Does the patient's condition qualify as a "serious health condition" described by any of the categories listed on the reverse side? If so, please place an X in the applicable box: 1. 2. 3. 4. 5. 6. None of these

4. Describe the medical facts that support your answer to item 3:
5. Date Condition Began:
6. Expected Duration:

7. Regimen of Prescribed Treatment *(Number of visits, treatment duration/nature, and referral to other health providers. Include visit/treatment schedule if medically necessary that employee work variable or reduced daily schedule or days per week.)*

a. By Physician or Practitioner:

b. By another health provider, if referred by Physician or Practitioner:

Please place an X in the Yes or No boxes below.
Yes No

If certification is for employee's seriously-ill family member, skip items 8 & 9 and go to items 10-14.

8. Is inpatient hospitalization of employee required?
9. Can employee perform the functions of assigned position? *(First review statement of employee position's essential functions or, if none provided, after discussing with employee.)*
10. Is inpatient hospitalization of family member (patient) required?
11. Does (or will) patient need help for basic medical, hygiene, nutrition, safety or transportation?
12. After reviewing employee's signed statement (Item 14), is employee's presence necessary, or would it be beneficial for care of the patient? *(This may include psychological comfort.)*
13. Estimated time period care is needed, or that employee's presence would be beneficial:

Item 14 is to be completed by employee requesting Family Leave.

14. Employee: For seriously-ill family member, please describe care you will provide, and estimated time period care will be provided, including a schedule if leave will be taken intermittently, or on other basis.

Type of Practice *(Field of specialization, if any)*

Employee Signature & Date

Physician or Practitioner Signature & Date

To physician/practitioner (“health provider”): A “**Serious Health Condition**” means an illness, injury, impairment, or physical/medical condition covering one of the following situations:

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 later treatment involving or consequent to such inpatient care.
2. *Absence Plus Treatment.* A period of incapacity of more than 3 consecutive calendar days (plus any later treatment/period of incapacity for the same condition), that also involves:
 - (1) At least 2 treatments by health provider, nurse or physician’s assistant under direct supervision of health provider; or health service provider, (e.g., physical therapist) under orders of, or on referral by, health provider; *or*
 - (2) At least one treatment by health provider which results in a regimen of continuing treatment under the supervision of health provider.
3. *Pregnancy.* Any period of incapacity due to pregnancy, or for prenatal care.
4. *Chronic Conditions Requiring Treatment.* A chronic condition which:
 - (1) Requires periodic visits for treatment by health provider, nurse or physician’s assistant under direct supervision of health provider;
 - (2) Continues over extended time period (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. Employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, health provider. Examples include Alzheimer’s, severe stroke, or 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 health provider, or by provider of health services under orders of, or on referral by, health 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 3 consecutive calendar days absent medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Please Note: Treatment includes examinations to determine if a serious health condition exists and evaluations of 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., antibiotic) or therapy requiring special equipment to resolve or alleviate condition. A regimen of treatment does not include taking 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 health provider.