SAMPLE FORM PREGNANCY

HEALTH CARE PROVIDER CERTIFICATION OF EMPLOYEE'S FAMILY MEMBER SERIOUS ILLNESS – FMLA

Employee's name JERRY JONES

Patient's name TERRY JONES

Relationship to employee X Spouse ____ Parent ____ Child (under age 18 or if older and incapable of self care due to a mental or physical disability)

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.*

(1) ____ (2) ____ (3) X (4) ____ (5) ____ (6) ____ None of the above ____

Describe the medical facts and/or treatment that meet the criteria of the category checked above (Medical diagnosis/prognosis is not required). MRS. JONES IS PREGNANT

Date condition commenced: NOV 2008 **Probable duration of condition:** 9 MONTHS

Probable duration of present incapacity (if different): ____

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ____ Yes X No

If no, would the employee's presence to provide psychological comfort be beneficial to the patient's recovery? ____

Note the probable duration of the need. ____

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment of the family member's serious health condition (e.g. follow-up treatment)? X Yes ____ No

If so, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:

Dates: VISITS EVERY 6 WEEKS NOW THEN WEEKLY IN FINAL 4 WEEKS OF PREGNANCY

Duration: 2-4 **hour(s) or** ____ **day(s) per episode.**

Period of Recovery: IMMEDIATE

Will the employee require leave on an intermittent or reduced schedule basis for the family member's serious health condition, that may result in unforeseeable episodes of incapacity (e.g. flare ups)? ____ Yes ____ No

If so, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: 1-2 **times per** 4 **week(s)** 6 **month(s):**

Duration: 8-16 **hour(s) or** 1-2 **day(s) per episode.**

If the employee requires leave on an intermittent or reduced schedule basis to care for a covered family member with a serious health condition, briefly explain why such care is medically necessary (this can include assisting in the family member's recovery).

IF MRS. JONES GETS ILL HER HUSBAND WILL NEED TO BE WITH HER TO PROVIDE ASSISTANCE AND PSYCHOLOGICAL SUPPORT

Health Care Provider's Name (Please print): MARY SMITH, MD

Health Care Provider's Signature: S/ MARY SMITH, MD **Date:** 3/10/09

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Specialty/Type of Practice: OBSTECTRICS