# State of Colorado Medical Certification Form

## Family Member's Health Condition

**Instructions to Department/Institution:** This completed form is to be placed in a separate, confidential medical file with limited access.

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**Instructions to Employee:** Complete this section prior to giving this form to your family member or his/her medical provider. If this document is returned incomplete, or contains vague/ambiguous responses, it will be returned to you for correction. Failure to provide a complete and sufficient certificate within 15 calendar days may result in denial of sick leave and the possible delay or denial of any applicable family/medical leave. Providing false information, knowingly, either directly or through another party, may result in corrective and/or disciplinary action.

| | |
|---|---|
| Employee's Name: | Employee ID: |
| Name of family member providing care for: | Relationship to the family member: |
| If family member is your son or daughter, date of birth: | Describe the care you will provide to your family member and estimate leave needed: |

Employee signature: _____ Date: _____

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**Instructions to Health Care Provider:** The employee listed above has requested leave to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown", or indeterminate" may not be sufficient to determine FMLA coverage. Be sure to sign the form on the last page and return to the employee. Limit your responses to the condition for which leave has been requested.

| | |
|---|---|
| Provider's name and business address: | Type of practice/medical specialty: |
| Telephone: ( ) | Fax: ( ) |

**Medical Facts**

1. Approximate date the condition began: _____
2. Probable duration of the condition: _____

**Mark As Applicable:**

1. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
No ____Yes ____ If so, dates of admission: _____

Date(s) you treated the patient for the condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition? No____ Yes_____

Was medication, other than over-the-counter medication, prescribed? No ____Yes ____

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? No____ Yes____. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No____ Yes ____. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave to care for the patient (such medical facts may include symptoms, diagnosis, or any regiment of continuing treatment such as the use of specialized equipment):

4. The attached sheet describes a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition meet one of these categories? Please check the category.
(1)____ (2)____(3)____(4)____(5)____(6)____, or none.

**Amount of Leave Needed**

5. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No ____ Yes ____ If so, estimate the beginning and ending date for the period of incapacity:

During this time, will the patient need care? No ____ Yes ____ If so, explain the care needed by the patient and why such care is medically necessary:

6. Will the patient require follow-up treatments, including any time for recovery? No ____ Yes ____

Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

Explain the care needed by the patient and why such care is medically necessary:

7. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? No ____ Yes ____

Estimate the hours the patient needs care on an intermittent basis, if any:
_____ hour(s) per day _____ days per week from _____ through _____

Explain the care needed by the patient and why such care is medically necessary:

8. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? No____ Yes____.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of the related incapacity that the patient may have over the next 6-months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ____times per week(s) or ____ times per months(s) Duration: ____hours or ____days(s) per episode

Does the patient need care during these flare-ups? No____ Yes____.

Explain the care needed by the patient and why such care is medically necessary:

**Additional Information (identify question number with your additional answer)**

**Signature of Health Care Provider** _____ **Date** _____

**Return completed form to the patient**

## Definitions for 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 any subsequent treatment in connection with such inpatient care.

2. Incapacity and 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 within 30 days of the first day of incapacity**, unless extenuating circumstances exist, by a health care provider, by a nurse 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 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.

   Treatment by a health care provider means an **in-person visit** to a health care provider. The first or only in-person treatment visit **must take place within 7 days of the first day of incapacity**.

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** (**at least twice a year**) for treatment by a health care provider, or by a nurse 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).

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 stage of a disease).

6. Multiple Treatments (Non-Chronic Condition).

   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 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), 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 there from.