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Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Certification of Health Care Provider for Employee's Own Health Condition Connecticut Family and Medical Leave Act

Employee's Name	Date of Birth

This form is to be completed by employee's Health Care Provider when employee is requesting Family Medical Leave and medical documentation is required.

NOTE: 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.

Description of serious health condition *(On page 2 of the 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) ☐ (4) ☐ (5) ☐ (6) ☐ None of the above

Describe the medical facts that meet the criteria of the serious health condition checked above and support the need for leave (Medical diagnosis/prognosis is not required)

If pregnancy, delivery date: anticipated_____ actual _____ ***choose one***

Date condition commenced _____

Probable duration of condition _____

Is leave medically necessary on an intermittent or reduced schedule basis for follow-up treatment of the employee's serious health condition, including pregnancy? ☐ Yes ☐ No

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

Dates _____

Duration: _____ hour(s) or _____ day(s) per episode

Period of recovery

Is leave medically necessary on an intermittent or reduced schedule basis for the employee's serious health condition, including pregnancy, that may result in 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: _____ times per _____ week(s) _____ month(s)

Duration: _____ hour(s) or _____ day(s) per episode

Is the employee able to perform work of any kind? ☐ Yes ☐ No

If yes, is it necessary for the employee to be absent from work for treatment? (Reference to the employee's inability to perform the essential functions is not applicable to Connecticut FMLA.) ☐ Yes ☐ No

Start date of required absence _____ End date of required absence _____

Health Care Provider's Name			
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice			

I certify that the information on this form is accurate and truthful to the best of my knowledge.

Signature of Health Care Provider	Date

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FMLA Description of Serious Health Condition[1]

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[2] in connection with such inpatient care.

2. **Absence Plus Treatment**

   A period of incapacity of more than three full consecutive days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   (a) 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 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

   (b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[3] under the supervision of a health care provider.

   The requirements for treatment by a health care provider means an in-person visit to a healthcare provider.

   The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.

3. **Pregnancy**

   Any period of incapacity due to pregnancy, or for prenatal care.

4. **Chronic Conditions Requiring Treatments**

   A chronic condition which:

   (a) Requires periodic visits of at least twice a year for treatment by a health care provider, or by a nurse under direct supervision of a health care provider;

   (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   (c) May cause episodic rather than a continuing period of incapacity[4] (e.g., asthma, diabetes, epilepsy).

5. **Permanent/Long-Term Conditions Requiring Supervision**

   A period of incapacity[4] 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, as 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 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[4] of more than three full consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), or kidney disease (dialysis).

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] 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.

[3] 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 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.

[4] "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 therefor, or recovery therefrom.

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