SAMPLE FORM EMPLOYEE DIABETES

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
X_ 4. **Chronic Condition**
__ 5. **Permanent Long-term Condition**
__ 6. **Multiple Treatments** (Non-Chronic Condition)

Describe the medical facts and/or treatment that meet the criteria of the serious health condition checked above. This may include symptoms; nature of the condition; dates of treatment; or any regimen of continuing treatment such as a course of prescription medication or therapy requiring use of specialized medical equipment. ***Medical diagnosis/prognosis is not required.*** **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

__Patient has been diagnosed with diabetes which has not been controlled by RX medications and diet to date. The disorder incapacitates the employee due the fatigue, nausea, vomiting, blurred vision and numbness in hands and feet.

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? January 2015

On which dates did you treat the Employee in the past 12 months? 1/25/15, 2/5/2015

How long do you project the condition to continue? Lifetime to be reviewed annually

How long will the Employee be incapacitated (if different)? 1 to 3 days

How long will the Employee need to be on leave because of the condition?

Intermittently 6 months to 1 year

Will the Employee need treatment at least twice per year for the condition? _X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? _X_ Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment:

Frequency of treatment/episodes of incapacity: 1-5 times per ___week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _1-3_ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery:

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? _X_ Yes ___No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? __ Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required:

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *APWU* Date: xx/xx/xxxx

Health Care Provider's Name (Please print): APWU

Address: 123 APWU Way

Telephone Number: xxx-xxx-xxxx Fax Number: xxx-xxx-xxxx

Specialty/Type of Practice: Internal Medicine