

Section B: (Continued)

Multiple Treatments for Non-Chronic Conditions – This situation is defined by any period of absence to receive **multiple treatments** 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 of more than three (3) consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, or radiation), severe arthritis (physical therapy), and kidney disease (dialysis). This also includes any time off for a period of recovery from treatments.

Section C: To Be Completed by Health Care Provider

Describe the **medical facts of patient** supporting your certification that would help us understand how the patient's condition meets one of the "Serious Health Condition" categories you checked.

Indicate whether incapacity is episodic, periodic, or extended, and the approximate date the condition commenced.

If additional treatments or a regimen of treatments will be required (by you or under your supervision), please provide a general description of the regimen (e.g., prescription drugs, physical therapy requiring special equipment.)

If the employee will be absent from work on an intermittent or part-time basis, please provide the following:

Probable number of treatments _____ Interval between treatment _____

Dates of treatment if known _____ Period required for recovery if any _____

If FMLA leave is for a family member, explain whether the family member requires physical and/or psychological assistance or comfort from the employee.

What is the actual or estimated duration of any incapacity of employee or the family member?

Employee's return to work date:

Section D: To Be Completed by Health Care Provider

Health Care Provider's Name:

Type of Practice:

Address:

Phone Number:

Health Care Provider's Signature:

Date: