Human Resources and Risk Management
155 South Seward Street
Juneau, Alaska 99801
Telephone: 907 586-5250, FAX: 907 586-4509
CBJLeaveAdmin@juneau.gov

Certification of Health Care Provider

Section A: Employee/Patient Information

Employee's Name:	Patient's Name:	Relationship of Patient to Employee:
[full-name]		☐ Self ☐ Parent ☐ Spouse ☐ Dependent Child _____ (Child's Age) ☐ Domestic Partner
Employee's Dept.:		

To be completed by person needing family leave <u>to care for a family member.</u> Attach a description of the care to be provided and estimate the time period for which it will be necessary, including a schedule if leave will be taken intermittently or on reduced leave schedule.

Signature of Employee: **Work #:** **Home #:** **Date:**

Release of Medical Information: I authorize the release of any medical information necessary to provide the information requested on this form.

Signature of Patient:		**Date:**	

Section B: Completed by Health Care Provider

1. Indicate the appropriate category of Serious Health Condition:

a. ☐ Hospital Care (definitions on reverse of form)
b. ☐ Absence Plus Treatment
c. ☐ Pregnancy/Prenatal
d. ☐ Chronic Conditions Requiring Treatment
e. ☐ Permanent/Long-term Conditions Requiring Treatment
f. ☐ Multiple Treatments (Non-Chronic Conditions)

2. Please describe the **medical facts** supporting your certification (medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of special equipment):

3a. Date condition commenced & probably duration:

3b. Date(s) of patient's **present incapacity** (if different from 4a):

4. NOTE: Please indicate type of absence requested:
Continuous: give duration of time off work: _____
Intermittent/Reduced Schedule: please estimate episodic absences based upon patient's past history:
Frequency of episodes: _____
Duration of episodes: _____

5. Prescribed treatment regimen & schedule:
Office visits: # _____per_____
Therapy visits: # _____per_____
Prescription medication: _____
Referral to other providers (who): _____
Surgery date: _____
Procedure (type/date): _____
Other treatments (type/dates): _____

EMPLOYEE'S OWN SERIOUS HEALTH CONDITION:

6. Is in-patient hospitalization of the employee required?
☐ Yes (give dates) _____ ☐ No

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

8a. Is employee able to perform the functions of employee's position? ☐ Yes ☐ No
8b. If not, please describe employee's restrictions (include need for reduced work schedule) and their duration:
Restrictions:

Duration:

FAMILY MEMBER'S SERIOUS HEALTH CONDITION:

9. Will the patient require assistance for basic medical, hygiene, nutritional, safety or transportation needs? ☐ Yes ☐ No

10. After review of the employee's signed statement above, is the employee's presence necessary and would it be beneficial for the care of the patient? (This may include psychological comfort.) ☐ Yes ☐ No

11. Estimate the period of time care is needed or the employee's presence would be beneficial to care for the patient.

Type of Practice (Field of specialization, if any):	Address of Health Care Provider:
Print name of Health Care Provider:	Office Telephone #:
Health Care Provider Signature:	Date signed:

Return Completed Form to Your Supervisor Revised 05/2023

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Family and Medical Leave Information Sheet

For purposes of family leave, **"serious health condition**" is an illness, injury, impairment, or physical or mental condition that involves one or more of the following:

1. **Hospital care/Inpatient Care[1]:** An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or as a result of such inpatient care.
2. **Absence plus 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
   (a) **Treatment[2] two or more times** within 30 days of the first day of incapacity by a health care provider, by a nurse or physician's assistant under the 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) **One visit for treatment** by a health care provider that result in a **regimen of continuing treatment3 under the supervision of the health care provider.** The first visit to a healthcare provider must occur within seven days of the first day of incapacity.
3. **Pregnancy/Prenatal Care:** Any period of incapacity due to **pregnancy** or for **prenatal care**.
4. **Chronic conditions requiring treatment:** A chronic condition which
   (a) Requires **at least two visits per year** for treatment by a health care provider or by a nurse or physician's assistant 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 (e.g., asthma, diabetes, epilepsy, etc.).
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 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, a 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) 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 consecutive calendar days in the absence of medical intervention or treatment,** such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

A Serious Health Condition Is Generally Not:

Allergies, stress, or substance abuse unless inpatient hospital care is provided, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health conditions; or voluntary treatment or elective surgery unless inpatient hospital care is required.

Notice to Medical Provider: 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, except as specifically allowed by this law. To comply with this law, the City and Borough of Juneau, as an employer, asks 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.

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

2 Treatment includes examination to determine if a serious health condition exists and evaluation 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., an antibiotic) or therapy requiring special equipment to resolve or elevate 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, or other similar activities that can be initiated without a visit to a health care provider.