CERTIFICATION BY HEALTH CARE PROVIDER

(Substitutes for DOL Form WH-380 E and F 1-1-2019)

INSTRUCTIONS FOR EMPLOYEE: Complete page two of this form and give all three pages to the health care provider. Upon return, verify for accuracy and completeness then submit all three pages to HR as a PDF (preferable), by fax to 859-363-2101, or on paper.

INSTRUCTIONS FOR HEALTH CARE PROVIDER: *NKY Health's employee[1] has requested leave which may be protected under the Family Medical Leave Act (FMLA) pertaining to your patient. Please answer all applicable parts of this page completely and be as specific as you can. Several questions seek a response as to the frequency or duration of a condition or treatment. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of your patient. Be sure to sign this form at the bottom and return it* ***to the patient or employee[1]*** *not to the Human Resources office. See page 3 for definitions.*

Employee's Name: _____ Patient's name (if different than employee): _____

PART A: MEDICAL FACTS

(Health care provider, *check all boxes that apply below and fill in associated blanks. See page 3 for definitions.*)

Approximate date condition(s) commenced: _____ Probable duration of condition(s): _____

The patient has a serious health condition that requires the following:

☐ Inpatient care in a hospital, hospice, or residential medical care facility: From: _____ To: _____

☐ Continuing treatment by a health care provider for (list condition(s)) _____ that involves any period of incapacity or treatment that is:

- ☐ Lasting more than three consecutive **calendar** days **and** either or both of the following:
  - ☐ Treatment two or more times per year by a health care provider.
  - ☐ One treatment by a health care provider with a continuing regimen of treatment (e.g. physical therapy, prescription medications).
- ☐ Related to pregnancy or for prenatal care – Expected delivery date: _____.
- ☐ For a chronic serious health condition (e.g. asthma, diabetes, etc.).
- ☐ Permanent or long term due to a condition for which treatment may not be effective (e.g. Alzheimer's).
- ☐ Due to any absences to receive multiple treatments that would likely result in a period of incapacity of more than three days if not treated (e.g. dialysis, chemo, radiation).

PART B: AMOUNT OF LEAVE NEEDED

(Health care provider, *check all boxes that apply below and fill in associated blanks. See page 3 for definitions.*)

☐ Patient will be incapacitated for a **single continuous period of time** due to his/her medical condition(s).
Anticipated period of incapacity: From: _____ To: _____

☐ Patient will be incapacitated **intermittently.** Based upon the patient's medical history and your knowledge of his/her medical condition (check all that apply):

- ☐ Patient's medical condition(s) will necessitate employee[1] working part-time or on a reduced schedule. The estimated work schedule the employee[1] needs is as follows (e.g. 4 hours work per day for next 2 months) - _____
- ☐ Patient's medical condition(s) will cause episodic flare-ups periodically preventing the employee[1] from working. It is necessary for the employee[1] to be absent from work during the patient's flare-ups. The *estimated* frequency of flare-ups and the duration of related incapacity over the next 6 months is as follows (e.g., 1 episode every 3 months lasting 1-2 days OR when symptoms present) - approximately _____

☐ Patient[1] will need to attend follow-up treatment appointments. The estimated treatment schedule and duration of visits/treatments is as follows (e.g. physical therapy twice per week for 4 weeks) _____

Signature of health care provider:_____

Address: _____ Phone Number: _____

NKYHEALTH
NORTHERN KENTUCKY HEALTH DEPARTMENT

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Date: _____ Type of practice/medical specialty: _____

[1] Employee may be either the patient or a caregiver of the patient.

TO BE COMPLETED BY THE EMPLOYEE NEEDING LEAVE TO CARE FOR A FAMILY MEMBER

When FMLA is needed to care for a seriously ill family member, the employee shall state the care s/he will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule (*e.g.* For the next six months, I will need to miss work for 4 hours every two weeks to drive my father to his treatment appointments and to consult with his health care provider on the treatment regimen). The employee must provide sufficient information for NKY Health to predict the employee's work schedule.

_____
_____
_____
_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize my health care provider listed below to provide such medical information concerning me to NKY Health Human Resources, as is necessary for determining qualification for an absence or leave under the Family and Medical Leave Act ("FMLA"). I understand that my FMLA leave may be conditioned on my agreement to this authorization, and any additional authorization requests. I understand that I have the right to revoke this authorization at any time by written notification to the provider listed below and by NKY Health Human Resources and I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that when information is used or disclosed based on this authorization, the information may be redisclosed by the recipient and no longer protected by the Standards for the Privacy of Individually Identifiable Health Information. I understand that I may keep a copy of this authorization and that it will expire at the end of the FMLA leave.

Signature of Patient/Representative: _____ Date: _____

Relationship to Employee (e.g. self, parent, child) _____

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of (e.g guardian of child.

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DEFINITIONS FOR ASSISTANCE TO HEALTH CARE PROVIDER WITH COMPLETING FORM

A **Serious Health Condition** means an illness, injury, impairment, or physical or mental condition that involves one of the following:

Inpatient Care

Inpatient care *(e.g.,* an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[1] or subsequent treatment in connection with or consequent to such inpatient care.

Continuing Treatment by a Health Care Provider which includes any of the following:

1. A period of incapacity[1] of more than three consecutive full calendar days and any subsequent treatment or period of incapacity[1] relating to the same condition that **also** includes either:
   (a) Treatment[2] two or more times by or under the supervision of a health care provider, (*e.g.*, an in-person visits within 7 days and both within 30 days of the first day of incapacity) or
   (b) Treatment[2] by a health care provider on at least one occasion which results in a regimen of continuing treatment[3] (*e.g.,* prescription medication, physical therapy) under the supervision of the health care provider.

2. Pregnancy - Any period of incapacity[1]related to **pregnancy**, or for **prenatal care.**

3. Chronic Serious Health Conditions Requiring Treatments
   Any period of incapacity or treatment for a chronic serious health condition which:
   (a) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   (b) Requires periodic visits (at least twice/year) to a health care provider and may involve occasional episodes of incapacity;
   (c) May cause episodic rather than a continuing period of incapacity[2] *(e.g.,* asthma, diabetes, epilepsy, etc.).

4. Permanent/Long-term Conditions Requiring Supervision
   A period of incapacity[1] which is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required rather than active treatment. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

5. Multiple Treatments (Non-Chronic Conditions)
   Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[1] 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), and kidney disease (dialysis).

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[1] **Incapacity** means inability to work, attend school, or perform other regular daily activities.

[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.,* an 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.

NOTICE TO HEALTH CARE PROVIDER WHEN COMPLETING FORM

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members with certain exceptions, including requests for family medical history to comply with the certification provisions of the FMLA or State or local family and medical leave laws, or pursuant to a policy (even in the absence of requirements of Federal, State, or local leave laws) that permits the use of leave to care for a sick family member and that requires all employees to provide information about the health condition of the family member to substantiate the need for leave.". If this exception provision is not applicable in your case, 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.