

DARTMOUTH COLLEGE MEDICAL CERTIFICATION FORM ^{2/02}

FOR FAMILY MEDICAL LEAVE AND SHORT TERM DISABILITY PLAN

Return form to: Dartmouth Benefits Office 7 Lebanon Street, Suite 203, Hanover, NH 03755

Fax: 603-646-1108

TO BE COMPLETED BY EMPLOYEE

Employee's Name	Social Security Number
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Patient's Name (if different from employee)

Complete this section if the Family Medical Leave is to care for a family member:
State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee's Signature _____ Date: _____

MUST BE COMPLETED BY HEALTH CARE PROVIDER

Date of examination	Date of onset of illness/injury
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First Date of Disability - (out of work)

Expected duration of incapacity	Expected date of return to work
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Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories below:

Does the patient's condition qualify as a "serious health condition" under any of the categories described? If so, please check the applicable category.

- (1) (2) (3) (4) (5) (6)

- Hospital Care** - Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with such inpatient care.
- Absence Plus Treatment** - A period of incapacity of more than three consecutive days, including any subsequent treatment or period of incapacity relating to the same condition that also involves:
 - Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider; or
 - Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.
- Pregnancy** - Any period of incapacity due to a pregnancy, or for prenatal care.
- Chronic Conditions Requiring Treatments** - A chronic condition which:
 - Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of the health care provider.
 - Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes).
- 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 continuing supervision of, but not by receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
- Multiple Treatments (non-Chronic Conditions)** - 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 consecutive calendar days in the absence of medical intervention or treatment.

Please complete next page >>

Section I

State the approximate **date** the condition commenced and the probable duration of the condition (and also the probable duration of the patient's present **incapacity** if different):

Will it be necessary for the employee to take work only **intermittently or on a reduced schedule** as a result of the condition? If yes, give possible duration.

If the condition is a **chronic condition or pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity**.

Section II

If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment on an intermittent or part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

If any of these treatments will be provided by **another provider of health services** (e.g. physical therapist), please state the nature of the treatments:

If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

Section III

(a) If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work of any kind**?

(b) If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or Dartmouth can supply you with information about the essential job functions)?

(c) If yes, please note the essential functions the employee is unable to perform.

If neither (a) nor (b) applies, is it necessary for the employee to be **absent from work for treatment**?

Section IV

If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

(a) If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

(b) If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Section V

I certify that I have completed the Health Care Provider Section of this form. Telephone number:

Print name of Health Care Provider

Signature of Health Care Provider

Date: