Parental and Family Leave
Certification Form

The individual listed in Section I is an employee of The Heritage Group or one its companies and has requested paid time-off under our Parental & Family Leave Policy. They have applied for birth parent leave because they are pregnant or family leave because an eligible family member has been diagnosed with a serious illness. This form asks health care providers for the information necessary for a complete and sufficient medical certification.

An employee who has requested bonding leave for the birth of a newborn child or a child placed for adoption or foster care **cannot** fill out this certification form as the form is not applicable to their leave type.

Confidentiality Policy: The Company treats records and documents relating to medical informal information, medical certifications, recertifications, or medical histories of employees or employees' family members created for leave of absence purposes as confidential medical records. These records and documents are maintained in separate files/records from the usual personnel file in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Section I – Employee Information *(completed by Employer)*

Employee Legal Name (First and Last)

Employee ID

Company Name

Date Certification Requested (mm/dd/yyyy)

This form must be returned by _____ (mm/dd/yyyy) *(must allow at least 15 days from date requested)*

Reason for Leave: Select

If reason for leave is birth of a child, please fill out the remaining fields for Section I. If reason is for a family member with a serious illness, proceed to Section II.

Job Information

Job Title *(attach job description to provide to health care provider)*

Regular Work Schedule

Essential Job Functions

Employee Legal Name (First and Last) | Employee ID

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Section II – Family Information *(completed by Employee)*

This section should be completed prior to providing it to your family member or family member's health care provider.

Name of family member for whom you will provide care

Select relationship of family member to you:

Select

Describe the care you will provide to your family member: *(check all that apply)*

- ☐ Basic medical, hygienic, nutritional, safety needs
- ☐ Physical care
- ☐ Psychological Comfort
- ☐ Transportation
- ☐ Other:

Give best estimate of the amount of leave needed to provide care as described above *(i.e., 3 months from Jan 1 – March 31)*

If reduced schedule is necessary to provide the care described above, give best estimate of reduced schedule *(i.e., from Jan 1 – March 31, I am able to work 4 hours per day, 3 days a week)*.

Employee Signature **Date**

Section III – Health Care Provider *(completed by health care provider)*

Please provide your contact information, complete all relevant parts of this Section, and sign below. Your patient or a family member of your patient has requested a leave for either their own care or to care for your patient. Under this leave policy, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition, please see the appendix at the end of this form.

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You also may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's Name

Type of Practice/Medical Specialty

Health Care Provider's Business Address

Email

Telephone

Fax

Part A: Medical Information

Limit your response to the medical condition for which the employee is seeking leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. Note: Under this policy, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Patient's Name

Approximate date the condition started or will start (mm/dd/yyyy)

Provide best estimate of how long the condition lasted or will last

For care of family member only. To qualify for this leave, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient *(e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological care)*.

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Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy)

☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____ (mm/dd/yyyy)

☐ **Incapacity plus Treatment:** *(e.g. outpatient surgery, strep throat)*

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will not be seen on the following date(s): _____ (mm/dd/yyyy)

☐ **Chronic Conditions:** *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions:** *(e.g. Alzheimer's, terminal stage of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions Requiring Multiple Treatments:** *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the Above:** If none of the above conditions were checked, no additional information is needed. Go to last page to sign and date the form.

If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks. (e.g. patient requires dialysis)

Part B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits under the Parental and Family Leave Policy apply.

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Due to the condition, the patient (☐ had / ☐ will have) planned medical treatment(s) (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): _____ (mm/dd/yyyy)

- If medical treatment has not been scheduled, provide best estimate of the duration of the treatment(s), including any period(s) of recovery: _____ (e.g. 3 days/week)
- Provide your best estimate of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the treatment(s).

Due to the condition, the patient (☐ was / ☐ will be) incapacitated for a continuous period of time, including any time for treatment(s) and/or recovery.

- Provide your best estimate of the beginning date: _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the period of incapacity.

For care of family member only. Due to the condition, it (☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

- Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

_____ _____

Provider Signature **Date**

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Appendix

Definitions of a Serious Health Condition

Inpatient Care

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.

Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious illness condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.