



**TO BE FILLED  
IN BY  
ATTENDING  
PHYSICIAN OR  
PRACTITIONER**  
*(Please print legibly.)*

(c) If condition is a **“chronic condition”** (as checked off under Section (1)) or **pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:  
 \_\_\_ Patient \_\_\_ is \_\_\_ is not presently incapacitated. *(check one)*  
 \_\_\_ **Duration** of episodes of incapacity = \_\_\_\_\_ *(hours or days, etc.)*  
 \_\_\_ **Frequency** of episodes of incapacity = \_\_\_\_\_ *(no. of times per week or month, etc.)*

(4) (a) If **additional treatments** will be required for the condition and/or the patient will be absent from work or other daily activities because of treatment on an **intermittent** or **part-time** basis, provide:  
 \_\_\_ An estimate of the probable **number** of such treatments. \_\_\_\_\_  
 \_\_\_ An estimate of the probable **interval between** such treatments. \_\_\_\_\_  
 \_\_\_ An actual or estimated **dates** of treatment, if known. \_\_\_\_\_  
 \_\_\_ Period required for **recovery**, if any. \_\_\_\_\_

(b) If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatment and period of time covered.  
 \_\_\_\_\_  
 \_\_\_\_\_

(c) 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). \_\_\_\_\_  
 \_\_\_\_\_

(5) (a) During the period of incapacity, is the employee **able to perform work of any kind?**  
 \_\_\_\_\_  
*(fill in “yes” or “no”)*

(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** (if FMLA leave or if relevant, a job specification is enclosed for your convenience)? \_\_\_\_\_  
*(fill in “yes” or “no”)*  
 If yes, elaborate. \_\_\_\_\_  
 \_\_\_\_\_

(c) If neither (4)(a) or (4)(b) applies, is it necessary for the employee to be absent from work for treatment? \_\_\_\_\_  
*(fill in “yes” or “no”)*

(6) The employee will be able to return to  **regular** or  **selective work** on \_\_\_\_\_ *(date)*. If selective work, explain under number (7) below.

(7) Additional remarks:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Physician or Practitioner <b>AND</b> Physician or Practitioner License Number <i>(please type or print)</i>			
Address <i>(No. and Street)</i>	(City or Town)	(State)	(ZIP Code)
Signed <i>(Physician or Practitioner)</i>	Date	Telephone	

## FEDERAL FMLA:

---

Under the federal FMLA, “**Serious Health Condition**” is defined as an illness, injury, impairment, or physical or mental condition that involves:

- Any period of incapacity or treatment related to inpatient care (i.e., an overnight stay in a hospital, hospice, residential facility, **OR**
- Continuing treatment by a health care provider.

“**Continuing treatment**” by a health care provider includes any one or more of the following:

- 1) Incapacity and 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:
  - Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, **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.Treatment means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within **seven** (7) days of the first day of incapacity.
- 2) Pregnancy: Any period of incapacity due to pregnancy, or for prenatal care.
- 3) Chronic Conditions Requiring Treatments: Any period of incapacity or treatment for such incapacity due to a chronic condition which:
  - Requires periodic visits for treatment by a health care provider or by a nurse physician’s assistant under direct supervision of 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. **Examples:** *asthma, diabetes, epilepsy.*
- 4) Permanent/Long-term Conditions: 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:** *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 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. **Examples:** *cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), and kidney disease (dialysis).*

**Note:** Substance abuse may be a serious health condition if the conditions mentioned above are met. However, FMLA leave may only be taken for *treatment* for substance abuse by a health care provider or by a provider of health care services on referral by a health care provider. On the other hand, absence *because of* the employee’s use of the substance, rather than for treatment, does **not** qualify for FMLA leave.

*Please Note:* For the purposes of federal FMLA the following terms are defined to mean:

- “**Incapacity**” – inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.
- “**Treatment**” – includes examinations to determine if a serious health condition exists and evaluations of the condition. It does not include routine physical examinations, eye examinations, or dental examinations.
- A “**regime 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. It 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.

---

---

**STATE FAMILY / MEDICAL LEAVE (C.G.S. 5-248a):**

Under the state's family/medical leave law, "Serious Illness" is defined as an illness, injury, impairment or physical or mental condition that involves:

- Inpatient care in a hospital, hospice, or residential care facility;
  - OR**
  - Continuing treatment or continuing supervision by a health care provider [C.G.S. 5-248a(c) and CT State Regulation 5-248b-1(d)].
- 
- 

**EMPLOYEE FITNESS FOR DUTY CERTIFICATION**

**Employee's name:** \_\_\_\_\_

**Supervisor:** \_\_\_\_\_

**Date leave commenced:** \_\_\_\_\_

**Date of return:** \_\_\_\_\_

I understand that following my medical leave under federal FMLA and/or C.G.S. 5-248a my restoration to employment is subject to the following conditions:

1. As a condition of restoration, I must provide a written certification from my health care provider certifying that I am able to resume working.
2. Every attempt will be made to restore me to my original position. If my original position is unavailable, I will be placed in an equivalent position with equivalent pay and benefits, unless contract specifies otherwise.
3. If I am returning from unpaid family and medical leave, I shall not be entitled to the accrual of any seniority or employment benefits during the period of leave, unless contract specifies otherwise.

**Employee's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

---

---

I have examined \_\_\_\_\_ and can certify that she/he is fully able to resume working on \_\_\_\_\_  
(employee name) (date)

---

---

---

**Health care provider's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Telephone:** ( ) \_\_\_\_\_  
(please print)

**Address:** \_\_\_\_\_

---

---