

NORTHWEST AIRLINES - FORM A
Certification of Family Medical Leave Request
Employee - Complete Section I only.

SERIOUS HEALTH CONDITION – EMPLOYEE

NWA Employee – complete Section I

SECTION I

1. Employee Name _____ 2. Employee No. _____
3. Case Number _____ 4. Date Form obtained by Employee _____
5. Employee's signature _____

HEALTH CARE PROVIDER (HCP) – complete Sections II, III and IV (A qualifying health care provider as defined by the federal Family Medical Leave Act must be the one who completes the responses requested in Sections II, III and IV.)

Identifying Information

SECTION II

7. Please print HCP: First Name _____ Last Name _____
8. HCP Signature: _____ 9. Date: _____
10. HCP License No. _____ 11. HCP Specialty _____
12. Business Address: _____ 13. Phone _____

Absence From Work

SECTION III

14. Is your patient *unable* to perform work of any kind?
a. Yes ⇒ Is he/she required to be absent from work for treatment? Yes No
b. No ⇒ Is he/she *unable* to perform one or more of his or her essential job functions? Yes No
If 14.b. is "yes": based on a discussion with your patient about his or her essential job functions, the essential functions your patient is unable to perform are _____

Serious Health Condition

15. Does your patient's condition qualify as an FMLA "serious health condition?" Yes No
If you answered "yes" to the question above, please check all boxes, if any, that apply and answer the remaining questions in Sections III and IV.

Pregnancy

- Inability to work due to pregnancy.
 Absence for prenatal care.

Inpatient Care (overnight stay in a hospital, hospice or residential medical care facility)

- Inpatient care.
 Period of incapacity in connection with inpatient care.
 Subsequent treatment in connection with inpatient care.

Absence to Receive Multiple Treatments (Non-Chronic Conditions):

- For restorative surgery after an accident or other injury or recovery therefrom.
 For a condition that would likely result in a period of incapacity of more than three consecutive calendar days if left untreated.

Permanent/Long-Term Condition under Your Continuing Supervision

- Permanent period of incapacity due to a condition for which treatment may not be effective.
 Long-term period of incapacity due to a condition for which treatment may not be effective.

Chronic Condition Requiring Treatment and Causing Incapacity

- Condition requires periodic visits for treatment by or under direct supervision of a health care provider.
 Condition continues over extended period of time.
 Condition may cause episodic rather than continuing period of incapacity.

Absence Plus Continuing Treatment

- Inability to work for more than 3 consecutive calendar days and treatment on 2 or more occasions by, under supervision of, or on referral by, a health care provider.
 Inability to work for more than 3 consecutive days and treatment on at least 1 occasion by a health care provider (HCP) which results in a regimen of continuing treatment under the supervision of the HCP.

None

- None of the above descriptions apply.

16. a. Please provide the medical facts which support your certification as to which part of the definition of "serious health condition", if any, applies to your patient's condition _____

- b. Please state how the medical facts meet the criteria of the definition: _____

Date and Duration of Serious Health Condition

SECTION IV

17. The approximate date that the serious health condition commenced is ____/____/____, and the probable duration of the serious health condition is _____.
18. The probable duration of the your patient's present inability to work is _____

Intermittent Leave

Please read the following (excerpted from FMLA regulations regarding "use of intermittent leave") and answer question 19.

- 825.117 For intermittent leave, there must be a medical need for leave (as distinguished from voluntary treatments and procedures) and it must be that such medical need can be best accommodated through an intermittent or reduced leave schedule.
- 825.203 Leave may be taken intermittently or on a reduced leave schedule when medically necessary for planned and/or unanticipated medical treatment of a related serious health condition by or under the supervision of a health care provider, or for recovery from treatment or recovery from a serious health condition.

19. a. Will it be medically necessary for your patient to take leave intermittently as a result of the serious health condition? Yes No
- b. If "yes", please indicate the probable duration of the need for your patient to take leave intermittently and also answer question 22 below _____

Chronic Conditions

If you indicated in Section III that your patient's condition is chronic, please complete question 20.

20. a. Is your patient presently incapacitated? Yes No
- b. Please indicate the frequency and duration of the current or expected episodes of incapacity: _____ hour(s) on the following specific dates (if known) _____, **or** _____ hour(s) **OR** _____ day(s) **DURING EACH** (check one) day **OR** week **OR** month beginning on ____/____/____ and ending on ____/____/____

Pregnancy

If you indicated in Section III that your patient's condition is pregnancy, please complete question 21.

21. a. Is your patient presently incapacitated? Yes No
- b. Please indicate the frequency and duration of the current or expected episodes of incapacity: _____ hour(s) on the following specific dates (if known) _____, **or** _____ hour(s) **OR** _____ day(s) **DURING EACH** (check one) day **OR** week **OR** month beginning on ____/____/____ and ending on ____/____/____

Additional Treatments

22. a. If additional treatments will be required for the serious health condition, please estimate the probable number of such additional treatments _____
- b. If you answered "yes" to question 19.a. (i.e., that your patient's incapacity will be intermittent):
- Estimate the probable number of treatments _____
 - Estimate the interval between treatments _____
 - Actual treatment dates _____, **or**
 - Estimated dates of treatment _____
 - Period required for recovery from treatment, if any _____
23. a. Will another provider provide any of the additional treatments referred to in question 22? Yes No
- b. If "yes", please describe the nature of the treatments _____

Please read the following (excerpted from FMLA regulations regarding "regimen of continuing treatment") and, if applicable, answer question 24.

- 825.114 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, is not, by itself, sufficient to constitute a regimen of continuing treatment.

24. a. Is a regimen of continuing treatment by the patient required under your supervision? Yes No
- b. If "yes", please provide a general description of the regimen _____