

CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS – FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of the ELM. Form PS 3971 must be completed by employee.

Employee's name JOHN SMITH

Description of serious health condition (On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.

(1) _____ (2) _____ (3) _____ (4) (5) _____ (6) _____ None of the above _____

Describe the medical facts and/or treatment that meet the criteria of the serious health condition checked above (Medical diagnosis/prognosis is not required): THE PATIENT IS BEING TREATED FOR A CHRONIC

PULMONARY CONDITION WITH RX MEDS AND VISITS EVERY 3 MONTHS

Date condition commenced: 2005

Probable duration of condition: LIFETIME

Probable duration of present incapacity (if different): APRIL 1 - APRIL 3

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment (e.g. follow-up treatment) of the employee's serious health condition, including pregnancy? Yes _____ No

If so, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:

Dates: JULY 17, 2009 AND OCT. 9, 2009

Duration: 2-4 hour(s) or _____ day(s) per episode.

Period of Recovery: IMMEDIATE

Will the employee require leave on an intermittent or reduced schedule basis for the employee's serious health condition, including pregnancy, that may result in unforeseeable episodes of incapacity (e.g. flare ups)? Yes _____ No

If so, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: 1 times per 4 week(s) 6 month(s):

Duration: 8-40 hour(s) or 1-5 day(s) per episode.

Is the employee able to perform the essential functions of employee's position? YES If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.

Health Care Provider's Name (Please print): JEFF JONES

Health Care Provider's Signature: S/ JEFF JONES

Date: 4/5/09

Address: 123 MAIN STREET, DALLAS TX 78220

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Specialty/Type of Practice: INTERNAL MEDICINE