

CERTIFICATION OF HEALTH CARE PROVIDER FAMILY AND MEDICAL LEAVE ACT OF 1993

EMPLOYEE INFORMATION		MEDICAL INFORMATION	
Name:		Physician:	
Address:		Address:	
City, State, ZIP:		City, State, Zip:	
Employee Phone:		Physician's Phone:	
Employee's Position:		Relationship of patient to employee:	
Patient Name (if other than employee):		Requested duration of leave:	From: _____ to _____

Return this completed form to the Indiana Harbor Belt Railroad Company, Attn: Human Resources, 2721 - 161st Street, Hammond, IN 46323, or fax this form to 219/989-4967.

1. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition ¹ qualify under any of the categories described? If so, please check the appropriate category.

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

2. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

- 3a. 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 ² if different):

Date condition commenced: _____

Probable duration of condition: _____

- b. Will it be necessary for the employee to work only intermittently as a result of the condition, including for treatment described in Item 4 below?

Yes _____ No _____

¹ Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

² "Incapacity, for purposes of the FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

- c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:
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- 4.a. 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 a 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:

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

PHYSICIAN: COMPLETE THIS SECTION ONLY IF PATIENT IS AN IHB EMPLOYEE. IF PATIENT IS NOT AN IHB EMPLOYEE, PLEASE COMPLETE SECTION 6 ON THE FOLLOWING PAGE.

- 5.a. If medical leave is required for the employee's absence from work because the employee's own condition (including absences due to pregnancy or a chronic condition), please indicate that the employee is unable to perform his or her job duties.

_____The employee is unable to perform his or her job duties due to his or her medical condition.

- b. If employee is unable to perform his or her job duties, is it necessary for the employee to be absent from work for treatment?

Signature of Physician or Health Care Provider

PHYSICIAN: COMPLETE THIS SECTION ONLY IF LEAVE IS REQUIRED TO CARE FOR A QUALIFYING FAMILY MEMBER.

- 6.a. 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?
 Yes _____ No _____
- b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _____
- c. **If the patient will need care only intermittently, please indicate the probable duration of this need:**

Signature of Physician or Health Care Provider

IHB EMPLOYEE: YOU MUST COMPLETE THIS SECTION FOR FAMILY LEAVE TO CARE FOR A FAMILY MEMBER:

Provide a statement describing the care you will provide and an estimate of the period during which care will be provided, including if leave is to be taken intermittently:

Employee Signature

Date

TO BE COMPLETED BY INDIANA HARBOR BELT RAILROAD MEDICAL REVIEW OFFICER

- _____ Leave time is reasonable and approval recommended.
- _____ Leave time is not reasonable and doctor recommends denial of same.
- _____ Leave time is not reasonable and should be _____ (estimate time of leave).

Remarks:

MEDICAL DIRECTOR'S SIGNATURE _____ / / _____

A **serious health condition** means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care:** Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.
2. **Absence Plus Treatment**
 - (a) A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
 - (1) Treatment³ by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
 - (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment⁴ under the supervision of a health care provider.
3. **Pregnancy:** Any period of incapacity due to pregnancy, or for prenatal care.
4. **Chronic Conditions Requiring Treatments.** A chronic condition which:
 - (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
 - (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - (3) May cause episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy)
5. **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 the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
6. **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, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

³ Treatment includes examination to determine if a serious health condition exists and evaluation of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ A regimen 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. A regimen of treatment 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.