



# CERTIFICATION OF HEALTH CARE PROVIDER

First Name	Last Name	Patient's name: (if different from employee)	
Street Address:			
City:	State:	Zip:	Telephone:
Employer Name:	Last Day Worked:	First Day Missed:	

**Release:** I authorize TRISTAR Benefit Administrators, my employer's leave administrator, to contact my health care provider, and I authorize my health care provider to communicate with TRISTAR Benefit Administrators, for purposes of clarification and authenticity of this medical certification.

Signature of Employee or Patient: \_\_\_\_\_

**COMPLETE THE FOLLOWING STEPS:**

STEP 1: Complete all of the above information above.

STEP 2: Complete the upper portion of page 2.

STEP 3: Complete page 3 if for Family Leave. (This portion of the form is to be completed for your physician only, NOT TRISTAR Benefit Administrators.)

STEP 4: Give all three pages (1, 2 & 3) to your physician and instruct them to complete.

After your physician has completed both pages 1 & 2 and signed the bottom of page 2, **fax the form to TRISTAR Benefit**

**Administrators at 562/495-6687 or mail to TRISTAR Benefit Administrators, PO Box 32363, Long Beach, CA 90832. TRISTAR Benefit Administrators only needs one copy of this form, so please choose one method of delivery only.**

**INSTRUCTIONS TO PHYSICIAN:** *Complete both page 1 & 2 and return to your patient or to TRISTAR Benefit Administrators directly as instructed above.*

**1. Serious Health Condition**

Does this person's condition qualify under any of the categories as described under the Family and Medical Leave Act as a **"serious health condition"**? If so, please check the applicable category. A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one or more of the following:

**Hospital Care:** Inpatient care 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.

**Absence Plus Treatment:** 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. Treatment two or more times 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 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 treatment under the supervision of the health care provider.

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

**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; and
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, etc.).

**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.

**Multiple Treatments (Non-Chronic Conditions):** Any period of absence to receive multiple treatments (including any period of recovery there from) 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, severe arthritis, and kidney disease.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Employer: \_\_\_\_\_

2. **Dates and Duration – for consecutive time frame only**

a. Approximate date the condition commenced: Start: \_\_\_\_\_

b. **Duration** of the condition: Start: \_\_\_\_\_ End: \_\_\_\_\_

c. Probable duration of the patient's absence from work: Start: \_\_\_\_\_ End: \_\_\_\_\_

**Dates and Duration – intermittent time frame only (or in conjunction with consecutive leave as described above)**

d. Will it be necessary for the employee to take leave only intermittently or to work on a less than full schedule as a result of the condition (including treatment described in Item 3 below)?  YES  NO

e. If intermittent, give the probable duration that the employee may need to be off work (actual date range is needed; unknown, undetermined, or as needed responses do not provide enough information to manage the absences):

Start: \_\_\_\_\_ End: \_\_\_\_\_

f. If intermittent, please describe/estimate the frequency of the employee's absences: (eg; hours missed per day, 1/2 days per week, 1-2 day intervals, per week or per month):

3. **Treatment**

a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

b. If the patient will be absent from work or other daily activities because of 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:

4. **Absence from Work**

a. **If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform any kind of work?**

YES  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** (the employee or the employer should supply you with information about the essential job functions, or if none provided, after discussing with employee)?

YES  NO

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment?**

YES  NO

5. **Family Care**

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, hygiene, nutritional needs, safety, or for transportation?

YES  NO

b. After review of the employee's signed statement (Item 6) does the condition warrant the participation of the employee?

YES  NO

c. Estimate the period of time care is needed or during which the employee's presence would be beneficial.

Start: \_\_\_\_\_ End: \_\_\_\_\_

d. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

Start: \_\_\_\_\_ End: \_\_\_\_\_

---

Name of Health Care Provider: \_\_\_\_\_ License #: \_\_\_\_\_

Address of Health Care Provider: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

6. To be completed by the employee requiring family leave to care for a serious ill family member. Please provide to the health care provider. **This information is not to be provided to TRISTAR Benefit Administrators or your employer.** When family care leave is required to care for a seriously ill family member, the employee must state the care he/she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

---

---

---

---

---

---

---

---

---

---

---

---

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date