

Supervisor's Check List for Determining FMLA/AFLA Leave

This form is to be completed by the supervisor when leave is requested by an employee that may be FMLA or AFLA leave.

Employee's Name: _____ SSN: _____

Information obtained from:

- _____ Certification of Health Care Provider (Attach, and skip to Determination.)
- _____ Employee
- _____ Employee's spokesperson

SERIOUS HEALTH CONDITION:

1. The leave request is due to: _____ Employee's own condition
_____ Condition of family member. If so, relationship: _____

2. Under which category does the condition qualify? _____

- (1) Hospital Care
- (2) Absence Plus Treatment
- (3) Pregnancy
- (4) Chronic Conditions Requiring Treatments
- (5) Permanent/Long-Term Conditions Requiring Supervision
- (6) Multiple Treatments (Non-Chronic Conditions).

_____ None of the above. THIS IS NOT AN FMLA NOR AFLA LEAVE.

_____ Cannot determine. REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER

Date condition commenced: _____

Probable duration of condition: _____

3. Describe the medical facts which support the categorization above, including a brief statement as to how the medical facts meet the criteria:

TREATMENTS:

4 a. Will the employee be absent from work or other daily activities because of treatment on an intermittent or part time basis?

_____ Yes

_____ No

_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER.

If Yes: Number of treatments: _____

Interval between treatments: _____

Dates of treatments: _____

Period of recovery: _____

4 b. Will the family member be absent from work or other daily activities because of treatment on an intermittent of part-time basis?

_____ Yes

_____ No

_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER.

If Yes: Number of treatments: _____

Interval between treatments: _____

Dates of treatments: _____

Period of recovery: _____

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

6. If a regimen of continuing treatment by the employee or family member is required under the supervision of the health care provider, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

INCAPACITY:

7. Is the employee or family member presently incapacitated?
_____ Yes
_____ No
_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER
If yes, give the probable duration: _____
8. If the condition is a chronic condition (condition #4) or pregnancy, are episodes of incapacity likely?
_____ Yes
_____ No
_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER
If yes, give the probable duration of episodes: _____
If yes, give the probable frequency of episodes: _____
9. Will it be necessary for the employee to work only intermittently or to work on a reduced schedule as a result of the condition?
_____ Yes
_____ No
_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION HEALTH CARE PROVIDER
If yes, give the probable duration: _____

ABILITY TO WORK:

10. Is the employee able to perform work of any kind?
_____ Yes
_____ No
_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER
11. 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?
_____ Yes
_____ No
_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER
If yes, please list the essential functions the employee is unable to perform:
12. If neither 10 nor 11 applies, is it necessary for the employee to be absent from work for treatment?
_____ Yes
_____ No
_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER

CARE PROVIDED:

13. Does the family member require assistance for basic medical or personal needs or safety, or for transportation?
_____ Yes
_____ No
_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER
If yes, give the probable duration: _____

14. Would the employee's presence to provide psychological comfort be beneficial to the family member or assist the family member's recovery?

_____ Yes

_____ No

_____ Unknown REQUEST THE EMPLOYEE COMPLETE A CERTIFICATION OF HEALTH CARE PROVIDER

If yes, give the probable duration: _____

15. State the care the employee will provide to the family member and an estimate of the period during which care will be provided. Attach a proposed schedule if leave is to be taken intermittently or if it will be necessary for the employee to work less than a full schedule.

HEALTH CARE PROVIDER:

Name of health care provider: _____

Type of practice: _____

DETERMINATIONS:

"Qualified" employee under FMLA: ___ Yes ___ No; under AFLA: ___ Yes ___ No

Condition qualifies under FMLA: ___ Yes ___ No ___ Unknown (Request Certification)

Condition qualifies under AFLA: ___ Yes ___ No ___ Unknown

Health care provider covered under FMLA: ___ Yes ___ No

Health care provider covered under AFLA: ___ Yes ___ No

Employee's own serious health condition lasting more than three calendar days: ___ N/A ___ Yes ___ No

Employee's own serious health condition lasting more than three working days: ___ N/A ___ Yes ___ No

___ Approved as FMLA leave

___ Disapproved as FMLA leave

___ Conditionally approved as FMLA leave, Certification of Health Care Provider requested.

___ Approved as AFLA leave

___ Disapproved as AFLA leave

Signature of supervisor

Date