AT&T AND PARTICIPATING COMPANIES
Certification of Health Care Providers for *Employee's Serious Health Condition*
Family and Medical Leave Act of 1993

Employee Name: **ATTUID:**

Leave Number: **Generated:**

SECTION TO BE COMPLETED BY EMPLOYEE: By signing this certification, you authorize your treating health care provider who is completing and signing this certification to verify with an authorized representative of AT&T, upon request, the information contained on this certification for purposes of clarification of the medical facts as permitted by section 825.307 of the FMLA regulations. You will have to complete a HIPAA authorization form with your health care provider. Denying permission to your treating health care provider to clarify the certification may result in the denial of FMLA leave if the certification is unclear.

Employee Signature: _____ **Date:** _____

Genetic Information Nondiscrimination Act of 2008 (GINA): The Genetic Information Nondiscrimination 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 or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Code of Business Conduct Statement: It is a Code of Business Conduct violation to tamper with or alter any portions of the medical certification that are to be completed by the physician or health care provider. Any tampering with or alteration of these sections by the employee will be considered a Code of Business Conduct violation that may lead to disciplinary action up to and including dismissal.

INSTRUCTIONS to the EMPLOYEE: Sufficient medical certification must be provided to support a request for leave no later than 20 calendar days from the date the employee received this form, absent extenuating circumstances. The due date for your certification form is: **XX/XX/XXXX**.
Failure to provide a complete and sufficient medical certification to HR Corporate Attendance & Leave Management Team, within 20 days may result in a denial of your request for leave under the Family and Medical Leave Act, applicable state leave laws, and/or company specific leaves. If the health care provider does not send the form on your behalf, then return this form or other sufficient medical certification to HR Corporate Attendance & Leave Management Team and keep a copy for your records.

- Upload required certification or documentation directly into LeaveLink from work using a mobile device, tablet, or PC or visit access.att.com from home and select Active Employee to log in with your AT&T Global Login Password.

NOTE TO EMPLOYEE: PLEASE PROVIDE ALL THREE (3) PAGES OF THIS FORM TO THE HEALTH CARE PROVIDER

ATTUID:

Serious Health Condition

The following sections are to be completed by the treating Health Care Provider only:

1. Does the patient's condition qualify as a Serious Health Condition under FMLA?

☐ NO, does not have a "Serious Health Condition" (go directly to Question # 12, sign and date)

☐ YES, has a "Serious Health Condition" (check applicable category box below)

"Serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse.

☐ **Hospital Care:** Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity (e.g. an inability to work or perform other regular daily activities) 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:
i) 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 (e.g. physical therapist) under orders of, or on referral by, a health care provider; or
ii) 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:** A period of incapacity due to pregnancy or for prenatal care.
Provide the expected delivery date: _____

☐ **Chronic Conditions Requiring Treatment:** A chronic condition which:
i) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under the direct supervision of a health care provider.
ii) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
iii) 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 that 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 continuous 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.

☐ **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 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), or kidney disease (dialysis).

ATTUID:

2. Diagnosis: _____

NOTE: In California and Connecticut, do not disclose the underlying diagnosis without patient consent.

Date condition commenced: _____ Duration of condition: _____

3. Date(s) patient has been ill and incapacitated: _____

4. Date(s) of recent office visits/follow-up visits, including telemedicine visits: _____

5. Hospitalized: Admission Date: _____ Release Date: _____

6. Will the patient need to have visits at least twice-yearly? ☐ Yes ☐ No

7. Was medication, other than over-the counter, prescribed? ☐ Yes ☐ No

8. If the patient was referred to another health care provider(s), provide Name & Medical Designation (i.e., MD, LCSW, etc.): _____

9. **Chiropractor (if applicable):** Was manual manipulation of the spine to correct a subluxation as demonstrated to exist by x-ray provided? ☐ Yes ☐ No

10. If absence from work is needed for treatment (e.g., appointments, therapy, etc.), provide **ONE frequency and duration** (e.g. 1 treatment per week, 1 day per treatment).

Frequency: _____ appointment(s) every _____ week(s) **OR** _____ month(s)

Duration: _____ hour(s) **OR** _____ day(s) per appointment

11. If the condition requires intermittent leave due to episodic flare-ups, provide **ONE frequency and duration** (e.g. 1 episode every 3 months, 1 day per episode).

Frequency: _____ episode(s) every _____ week(s) **OR** _____ month(s)

Duration: _____ hour(s) **OR** _____ day(s) per episode

12. HEALTH CARE PROVIDER INFORMATION:

_____ _____ (_____)_____

Signature of Health Care Provider Date Telephone

Printed Name & Medical Designation (MD, LCSW, etc.): _____

Address: _____ _____ _____ _____

Street City State Zip Code

Type of practice / Medical specialty: _____