TRISTAR

CERTIFICATION OF HEALTH CARE PROVIDER – CT

Employee 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, my employer's leave administrator, to contact my Health Care Provider, and I authorize my Health Care Provider to communicate with TRISTAR, for purposes of clarification and authenticity of this medical certification.
Signature of Employee or Patient: _____**Date:** _____

COMPLETE THE FOLLOWING STEPS:
STEP 1: Complete all of the information above. Sign the release.
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 Health Care Provider only, NOT TRISTAR.)
STEP 4: Give all three pages (1, 2 & 3) to your Health Care Provider and instruct them to complete. After your Health Care Provider has completed both pages 1 & 2 and signed the bottom of page 2,

- **fax the form to TRISTAR at 562/495-6687**
- **email the form to ICSFax@tristargroup.net**
- **mail the form to TRISTAR, 2835 Temple Avenue, Signal Hill, CA 90755**

TRISTAR only needs one copy of this form, so please choose one method of delivery only.

INSTRUCTIONS to the HEALTH CARE PROVIDER: *Complete both page 1 & 2 and return to your patient or to TRISTAR 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:

☐ The patient does not have a serious health condition.

☐ **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 therefrom) 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.

Employee Name: _____ Employer: _____

2. Medical Facts – Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories.

_____

_____

3. 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 incapacity: 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 4 below)? ☐ YES ☐ NO

i. Duration of intermittent leave: Start: _____ End: _____

e. If the condition is a chronic condition or pregnancy, is the patient presently incapacitated? ☐ YES ☐ NO

i. Duration of incapacity: Start: _____ End: _____

ii. Frequency of incapacity (e.g. hours missed per day, ½ days per week, 1-2 day intervals, per week or per month.)

_____

4. 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:

_____

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

_____

d. If a regimen of continuing treatment by patient is required under your supervision, provide a general description of such regimen (e.g. prescription drugs, physical therapy requiring special equipment):

_____

5. 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 (a) does not apply, is it necessary for the employee to be **absent from work for treatment?**

☐ YES ☐ NO

6. 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 or personal needs or safety, or for transportation?

☐ YES ☐ NO

b. Would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

☐ YES ☐ NO

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

Start: _____ End: _____

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.

Name of Health Care Provider: _____

Address of Health Care Provider: _____

Office Phone: _____Office Fax: _____

Signature of Health Care Provider: _____Date: _____

Employee Name: _____ Employer: _____

ITEM 7 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY CARE LEAVE
******* TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER *******
THIS INFORMATION IS NOT TO BE PROVIDED TO TRISTAR OR YOUR EMPLOYER.

7. 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 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:

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_____ _____

Signature of Employee **Date**