

Certification For Disabled Adult Child For Coverage Under FMLA

Employee Name: _____ Patient Name: _____

Company Name: _____ FMLA Leave Number: _____

This form must be completed, along with the Certification Form for Leave for care of a Family Member, and returned to us via fax.

An employee may take FMLA leave to care for a child who is 18 years of age or older if the adult child is incapable of self-care because of a mental or physical disability. A disability is a condition that substantially limits a major life activity. The adult child is incapable of self-care if active assistance or supervision is required to provide daily self-care in three or more activities of daily living. The presence of a disability should be evaluated based on the adult child's condition at the time that the leave is to commence.

Step 1: Certify that a Disability Exists.

At the time of leave, does your patient have a physical or mental impairment that substantially limits a major life activity as compared to most people? Yes No

If yes, what major life activity/ies is/are limited by the impairment?

- | | | | | |
|------------------------------------------|--------------------------------------------------|-----------------------------------|-----------------------------------|--------------------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Hearing | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Interacting With Others | <input type="checkbox"/> Reading | <input type="checkbox"/> Standing | |
| <input type="checkbox"/> Caring For Self | <input type="checkbox"/> Learning | <input type="checkbox"/> Seeing | <input type="checkbox"/> Thinking | |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Working | |

If yes, what major bodily function(s) is/are affected by the impairment?

- | | | | |
|-----------------------------------------|----------------------------------------|------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Digestive | <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Reproductive |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological | <input type="checkbox"/> Special Sense Organs & Skin |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hemic | <input type="checkbox"/> Normal Cell Growth | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Circulatory | <input type="checkbox"/> Immune | <input type="checkbox"/> Operation of an Organ | |

What is the expected duration of the impairment, including any residual effects?

Start Date: _____

End Date: _____

Step 2: Describe Assistance Needed with Self-Care.

At the time of the leave, is that patient incapable of completing at least three (3) activities of daily living, such as bathing, dressing, cooking or taking public transportation, and require assistance from the parent requesting FMLA leave? Yes No

If yes, what three (3) activities of daily living is your patient incapable of? Please describe.

Step 3: Sign.

Medical Professional's Signature: _____ Date: _____

Phone: 877-462-3652

Confidential Fax: 877-309-0218