



**SHORT-TERM DISABILITY
PHYSICIAN'S CERTIFICATION**
and/or
**FAMILY MEDICAL LEAVE
PHYSICIAN'S CERTIFICATION FOR:**
EMPLOYEE'S OWN ILLNESS
or
TO CARE FOR A FAMILY MEMBER

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UE-738 Front/Page 1 (01-01-11) – FAMILY MEDICAL LEAVE ACT (FMLA)

Note: Based on eligibility, absences under USEC policies due to a serious health condition of the employee (short-term disability) are usually coded against the Family and Medical Leave and/or other state laws after Benefits reviews and approves this certification.
Provider: Here and elsewhere on this form, the information sought is related only to the current condition for which the employee is requesting short-term disability and/or Family and Medical Leave. The employee (or patient, if different) hereby authorizes you to furnish information pertaining to his/her current medical condition to USEC and its agents (such as Benefit Plans, Plant Medical Director, etc.). **Any charges incurred in providing this information are the responsibility of the employee.**

EMPLOYEE MUST COMPLETE THIS SECTION			
Employee's Name (First, MI, Last)	Badge No.	Department No.	Payroll ' Hourly ' Salary
Employee's Signature	Date	Employee's Social Security No. (Last 4 digits)	
Home Phone No.	Manager's Name		Manager's Phone No.
Patient's Name and Date of Birth	Patient's Signature (if different from employee)	Relationship to Employee	Date

What is meant by a "serious health condition" under the Family and Medical Leave Act of 1993?
A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

- Hospital Care:** Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity¹ or subsequent treatment in connection with or consequent to such inpatient care. *(Complete 1a below and appropriate sections on page 2)*
- Absence plus treatment:** a period of incapacity¹ of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity¹ relating to the same condition), that also involves: *(Complete 1b below and appropriate sections on page 2)*
 - Treatment two or more times** by or under the direct supervision of a health care provider (i.e., **two in-person visits, the first within 7 days and both within 30 days of the first day of incapacity**); or
 - Treatment** by a health care provider on **at least one occasion (i.e., an in-person visit within 7 days of the first day of incapacity)** which results in a **regimen of continuing treatment²** under the direct supervision of the health care provider.
- Pregnancy:** any period of incapacity¹ due to **pregnancy**, or for **prenatal care**. *(Complete 1c below and appropriate sections on page 2)*
- Chronic conditions requiring treatment which:** *(Complete 1d below and appropriate sections on page 2)*
 - Requires **periodic visits for treatment at least twice a year for the same condition** by a health care provider, or by a nurse or physician's assistant **under direct supervision of a health care provider**;
 - Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
 - May cause **episodic** rather than a continuing period of incapacity¹ (e.g., Asthma, diabetes, epilepsy, etc.)
- Permanent/long-term conditions requiring supervision:** a period of **incapacity¹**, 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**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease. *(Complete 1e below and appropriate sections on page 2)*
- 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 or by a provider of health care 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 incapacity¹ 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), and kidney disease (dialysis). *(Complete 1f below and appropriate sections on page 2)*

¹"Incapacity" for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.
² A regimen of continuing treatment includes, for example, a course of prescription medication (e.g. antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

FOLLOWING SECTIONS MUST BE COMPLETED BY PHYSICIAN'S OFFICE AND NOT EMPLOYEE

EMPLOYEE'S OWN ILLNESS – COMPLETE QUESTIONS 1 THROUGH 19	TO CARE FOR A FAMILY MEMBER – COMPLETE QUESTIONS 1 AND 20 ONLY
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1. Does the **patient's condition** qualify under any of the categories described above? **If so, please check the applicable category below and include medical facts which meet the criteria of one of these categories to support your certification:**

- ____ Date(s) of inpatient hospital care: _____
- ____ Date(s) of office visit(s): _____ Course of prescription medications: Yes ____ No ____
- ____ Expected date of delivery: _____
- ____ Date(s) of office visit(s) for chronic condition: _____
- ____ Under continuing supervision of health care provider for a permanent/long-term condition: Yes ____ No ____
- ____ Dates of multiple treatments for non-chronic condition: _____

or ____ **None of the above**

Employee's Name _____		
2. Diagnosis, including complications:		3. ICD-9 Code (Please include for Claims Management):
4. State the approximate date the condition commenced , and probable duration of the condition (and also probable duration of the patient's present incapacity, if different):		
5a. Condition is: ' Acute ' Recurrent ' Chronic	5b. May require intermittent absence from work: (1-3 days or less at a time) ' Yes ' No	
6a. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition: ' Yes ' No	6b. If yes, give the probable duration if the condition is a chronic condition or pregnancy , and <u>state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:</u>	
7. If absences from work may be necessary because of treatment on an intermittent or part-time basis, please indicate: • Estimated number of days in a six month period employee may be off for this condition _____, • Interval between such treatments _____, • Actual or estimated dates of treatment, if known _____, • Period required for recovery, if any _____.		
8. 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:		
9. The patient has been unable to work since (first day sick):	Did this sickness/injury arise from patient's employment? ' Yes ' No If yes, date of injury _____	11. Next appointment:
12. Earliest date employee can return to work without restrictions: (The date must be listed for employee to receive disability benefits. Revisions must be submitted if employee is disabled beyond the date listed above.)	13. Please check here to receive an outline of employee's physical requirements and the essential function of employee's job to determine if the employee can return to work with restrictions. ' _____	
14. 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: a) unable to perform work of any kind? ' Yes ' No b) unable to perform any one or more of the essential functions of the employee's job? ' Yes ' No If yes, please list the essential functions the employee is unable to perform: c) If neither a nor b applies, is it necessary for the employee to be absent from work for treatment? ' Yes ' No		
COMPLETE ONLY IF SURGERY INVOLVED:	15. Date of Surgery:	PADUCAH, KY and PORTSMOUTH, OH USW EMPLOYEES ONLY: 16. Please indicate if this was an outpatient surgery procedure or treatment that would have otherwise required overnight hospitalization: ' Yes ' No
17. Nature of Procedure:		
18a. Name of Hospital:		18b. Admission Date: 18c. Discharge Date:
COMPLETE ONLY IF PREGNANCY INVOLVED:	19a. Estimated Delivery Date:	19b. Normal Pregnancy: ' Yes ' No If no, please describe complications:
20. Complete only if leave is required to care for a family member of the employee with a serious health condition: a. If leave is required to care for a child 18 years of age or over, does the child have a serious health condition and is he/she permanently incapable of self-care? If so, have you attached medical documentation to certify both of these conditions? ' Yes ' No b. 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 c. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ' Yes ' No d. If the patient will need care intermittently or on a part-time basis, please indicate the expected number of days or total elapsed time (beginning and end date) the employee will need to be off work to care for the family member (patient):		
Physician's Signature (Must be signed by Physician for Disability Pay)		Date
Printed Name of Physician		Type of Practice
Address (Street, City, Zip Code)		Fax Number Phone Number