

**SECTION 1: TO BE COMPLETED BY EMPLOYEE**
**INSTRUCTIONS to the EMPLOYEE:**

**This form is required in addition to the Family Member Serious Health Condition Certification form in order to determine whether you are eligible for FMLA family care leave because your adult child (age 18 or older) meets the definition of a child under the FMLA.**

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for an absence that may qualify as FMLA leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA Absence request.

Please complete Section 1 before giving this form to your child's health care provider. Section 2 of this form must be completed by the treating health care provider; it is inappropriate for it to be completed by anyone other than that provider.

Note: If this is a request for leave for a serious injury or illness for a covered service member, this form is not needed. Please obtain either: *Serious Injury or Illness of a Current Servicemember Certification* or *Serious Injury or Illness of a Veteran Certification* from your human resources office.

Employee Name		Personnel Number
Agency		Work Location
Family Member / Patient Name	Relationship to Employee	Son/Daughter Date of Birth

**SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER:**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for an adult child. In order to determine if the adult child has a mental or physical disability and is considered a "child" as defined by the FMLA, please answer the questions below. Please be sure to sign the form on the last page. The following definitions apply:

**Mental or physical disability** is defined under the FMLA as a disability that is a mental or physical impairment that substantially limits one or more of the major life activities of an individual. Conditions that are episodic or in remission are considered disabilities if the condition would substantially limit a major life activity when the condition is active.

**Major life activities** include, but are not limited to, activities such as caring for oneself, performing manual tasks, seeing, eating, walking, standing, reaching, breathing, communicating, and interacting with others, as well as major bodily functions, such as functions of the brain or immune system, or normal cell growth.

**Incapable of self-care** means that the individual **requires active assistance or supervision** to provide daily self-care in three or more of the activities of daily living (ADL's) or instrumental activities of daily living (IADL's). Activities of daily living include adaptive activities such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating. Instrumental activities of daily living include cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, using a post office, etc.

1. Does the adult child have a mental or physical disability as defined above?     Yes     No

If yes, please explain how the disability substantially limits one or more major life activity.

2. Is the adult child incapable of self-care due to the disability?     Yes     No

Employee Name \_\_\_\_\_

Personnel Number \_\_\_\_\_

If yes, please list below the ADL's and IADL's with which the adult child requires active assistance or supervision.

**By providing my original signature, the undersigned health care provider certifies that the information is true and accurate.**

Printed Name of Health Care Provider	Type of Practice/Medical Specialty	License Number
Address		Telephone Number
Name and Title of Person Completing the form, if not the Health Care Provider		Fax Number
Signature of Health Care Provider		Date

***Please return this form to the employee listed at the top of page 1 or to:***

**FMLA Specialist  
HR Service Center - FMLA  
PO Box 824  
Harrisburg, PA 17108-0824**

**Phone: (717) 346-4667 Fax: (717) 425-5389 Email: [RA-SPFabsence@pa.gov](mailto:RA-SPFabsence@pa.gov)**