KAISER PERMANENTE®

VISIT VERIFICATION/FAMILY LEAVE Health Care Provider Certification

Barosa

Patient Name

Identification 04295024

Fernando

IMPRINT AREA

(This section must be completed and determined by **treating provider** only)

THE ABOVE NAMED PERSON:

☐ **NO,** does not have a "Serious Health Condition" (see reverse for further information) **OR**

☐ **YES,** has a "Serious Health Condition", as defined below *(check one)*:

1. ☐ Hospital care
2. ☐ Absence plus treatment
3. ☐ Pregnancy
4. ☐ Chronic condition requiring treatment
   - ☐ **Is** currently incapacitated
   - ☐ **Is not** currently incapacitated
5. ☐ Permanent/long-term condition requiring supervision
6. ☐ Multiple treatments (non-chronic condition)

☐ Has a "Serious Health Condition" and requires a family member to take time off from work to provide basic medical, personal or safety needs, transportation, or psychological comfort. The probable frequency and duration of this need is _____

☐ Estimated date of Surgery/Procedure/Delivery: _____

☐ Diagnosis (Complete on patient request only): _____

THE ABOVE NAMED PERSON:

☐ Was seen at this office on: _____ ☐ Has been given telephone advice on: _____

☒ Has been ill and unable to attend work/school/physical education 7/6/05 through 8/6/05

☐ **States** he/she has been ill and unable to attend work/school/physical education _____ through _____

☐ **Can return to full duties with NO RESTRICTIONS on** _____ **OR**

☐ **Can participate in a modified work program starting** _____ **and continuing to** _____

(Please note: If modified work is not available, this patient is then unable to work for this time period.)

☐ Restrictions: _____ hours per day _____ hours per week

BASED ON AN 8-HOUR DAY EMPLOYEE CAN:

stand/walk	_____ minutes per hour	_____ total hours	☐ no restrictions
sit	_____ minutes per hour	_____ total hours	☐ no restrictions
drive	_____ minutes per hour	_____ total hours	☐ no restrictions

LIFT/CARRY (Occasionally = up to 1/3 workday. Frequently = up to 2/3 workday):

0-10 lbs.	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
11-25 lbs.	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
26-40 lbs.	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions

Can lift/carry up to _____ **lbs.**

EMPLOYEE IS ABLE TO:

bend	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
squat	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
kneel	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
climb	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
reach above shoulders	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
perform repetitive hand motions	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions

ASSISTIVE DEVICES? (e.g., cast, brace, crutches) _____

RESTRICTIONS: _____

OTHER: _____

TREATMENT PLAN: _____

☐ Medication effects which could impair performance: _____

☐ Physical therapy required. Frequency: _____

EXHIBIT 10
Deponent K. Ayres
Date 8/27/08 Rptr. KA
WWW.DEPOBOOK.COM

NOTE: If patient is **industrial, physician** signature is **REQUIRED.**

SIGNATURE AND TITLE _____ DATE 9/6/05

NAME (PRINT) Frank Dustin MD LOCATION/ADDRESS OAK Neurology PHONE 925-6509

98082 (REV.2-03) DISTRIBUTION: WHITE = CHART • PINK & CANARY = PATIENT

VISIT VERIFICATION/FAMILY LEAVE Health Care Provider Certification

For the *Patient*

The visit verification form confirms that you have had a visit with your health care provider. Additional health certification information is included on this copy of the form. This information meets the *medical certification* requirements of the *Family and Medical Leave Act* (FMLA) and can be used to document and request family leave from your employer. Your employer should also be able to answer any questions that you may have about family leave, including qualifications and eligibility.

For the *Treating Health Care Provider*

Certification regarding "Serious Health Conditions" must be determined and completed by the **treating health care provider** only. Ordinarily, unless complications arise, illnesses such as the common cold, flu, upset stomach, and headaches other than migraines do not qualify as "Serious Health Conditions". A "Serious Health Condition", as defined by the FMLA, means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. HOSPITAL CARE

Inpatient care (i.e., an overnight stay) 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.

2. ABSENCE PLUS TREATMENT

A period of incapacity of **more than three consecutive calender days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

a. **Treatment** *(includes examinations to determine if a serious health condition exists and evaluations of the condition; does not include routine physical exams, eye or dental exams)* **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

b. **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** *(includes for example, a course of prescription medication [e.g., an antibiotic] or therapy requiring special equipment to resolve or alleviate the health condition; does not include for example, 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)* under the supervision of the health care provider.

3. PREGNANCY

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. CHRONIC CONDITIONS REQUIRING TREATMENTS

A **chronic condition** which:

a. 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;

b. continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

c. may cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. 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.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. 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 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 incapacity of more than three consecutive calender days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).