AT&T AND PARTICIPATING COMPANIES
Certification of Health Care Provider for
Employee's Serious Health Condition
Family and Medical Leave Act of 1993

Employee Name: ATTUID:

Leave Number: Generated:

INSTRUCTIONS to the EMPLOYEE: Sufficient medical certification must be provided to support a request for leave no later than 20 calendar days from the date the employee received this form, absent extenuating circumstances. The due date for your certification form is: <CertificationDueDate>. Failure to provide a complete and sufficient medical certification to HR Corporate Attendance & Leave Management Team, within 20 days may result in a denial of your request for leave under the Family and Medical Leave Act, applicable state leave laws, and/or company specific leaves. If the health care provider does not send the form on your behalf, then return this form to HR Corporate Attendance & Leave Management Team, in one of the following options below.

Return this form or other sufficient medical certification to HR Corporate Attendance & Leave Management Team and keep a copy for your records:

- Upload required certification or documentation directly into LeaveLink using a mobile device, tablet or PC from https://claimlookup.com/attidsc.
- Mail the original to: AT&T HR Corporate Attendance & Leave Management Team, 105 Auditorium Circle, 12th Floor San Antonio, Texas 78205

NOTE TO EMPLOYEE: PLEASE PROVIDE ALL SIX (6) PAGES OF THIS FORM TO THE HEALTH CARE PROVIDER.

Code of Business Conduct Statement:

It is a Code of Business Conduct violation to tamper with or alter any portions of the medical certification that are to be completed by the physician or health care provider. Any tampering with or alteration of these sections by the employee will be considered a Code of Business Conduct violation that may lead to disciplinary action up to and including dismissal.

SECTION TO BE COMPLETED BY EMPLOYEE:

By signing this form I hereby authorize the treating health care provider who will or has completed and signed this certification form to verify with an authorized representative of AT&T, upon request, the information contained on this form for purposes of clarification of the medical facts as permitted by section 825.307 of the FMLA regulations. You will have to complete a HIPAA authorization form with the health care provider. Denying permission to the treating health care provider to clarify the certification may result in the denial of FMLA leave if the certification is unclear.

Employee Signature: ______________________________________Date:____________________

HEALTHCARE PROVIDER SECTION:

The following sections are to be completed by the treating HealthCare Provider only:

Note: Any changes/additions must be initialed and dated by the health care provider or authorized representative only.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under FMLA. Answer, fully and completely, all applicable sections. Several questions seek a response as to the frequency or duration of the condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as **"lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses** to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

The Genetic Information Nondiscrimination 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 or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART A: MEDICAL FACTS

Does the patient's condition qualify as a "Serious Health Condition" under FMLA?

_____No, not a **"Serious Health Condition". Ordinarily, unless complications arise, the common cold, the flu,** earaches, upset stomach, minor ulcers, headaches other than migraines, routine dental or orthodontia problems or periodontal disease are not serious health conditions. *(If No, additional medical facts are not required and you may proceed to the health care provider signature section.)*

_____Yes, **has a "Serious Health Condition" which is an illness, injury, impairment or physical or me**ntal condition that involves inpatient care as defined in §825.114 or continuing treatment by a health care provider as defined in §825.115.

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following: (Please select a category below)

- ☐ Hospital Care
- ☐ Absence Plus Treatment
- ☐ Pregnancy
- ☐ Chronic Conditions Requiring Treatment
- ☐ Permanent/Long-Term Conditions Requiring Supervision
- ☐ Multiple Treatments (Non-Chronic Conditions)

NOTE: SEE APPENDIX ON PAGE 5 FOR DEFINITIONS

1. Approximate date condition commenced: ____________________

   Probable duration of condition: ____________________

   Mark the following as applicable:

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ☐ Yes ☐ No If yes, provide dates below:

   Admission Date: ____________ Release Date: ____________

   Date(s) of last office visit for this condition: ____________________

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

   Was the patient referred to any other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ☐ Yes ☐ No

   Referred to Health Care Provider Name & Medical Designation (i.e. MD, LCSW, etc.):
   ____

   If yes, state the nature of such treatments and expected duration of treatment:

   ____

   ____

   Chiropractor Information (if applicable)
   Did you provide treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated to exist by x-ray? ☐ Yes ☐ No Date of last x-ray: ____________

2. Is the medical condition pregnancy? ☐ Yes ☐ No If yes, expected delivery date: ______________________

3. For the following question, use the job information provided by the employer. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.
   Is the employee unable to perform any of his/her job functions due to the condition: ☐ Yes ☐ No

   If yes, identify the job functions the employee is unable to perform:

   ____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   NOTE: In California and Connecticut, do not disclose the underlying diagnosis unless you have received consent from the patient.

   ____

   ____

   ____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

   If yes, provide the beginning and end dates for the continuous period of incapacity:

   Begin Date: ________________ End Date: ________________
   Estimated Return to Work Date: ________________

   Definition of Incapacity: Incapacity for the 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 therefore, or recovery there from.

6. Will the employee need to attend follow-up treatment appointments because of the employee's medical condition? ☐ Yes ☐ No

   If yes, please provide the estimated treatment schedule, including the dates of any scheduled appointments and the time required for each appointment, plus any recovery period (e.g. 1 appointment every 3 months, and requires 1 day of recovery per appointment):

   Frequency: _____ appointment(s) every _____ week(s) *or* _____ month(s)

   Duration: _____ hours *or* ___ day(s) per appointment

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No
If yes, explain:

____

If yes, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ episode(s) per _____ week(s) *OR* _____ month(s)

Duration: _____ hours *OR* ___ day(s) per episode

Note to Health Care Provider: Provide both Frequency (how often) and Duration (how long)
ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____

____

____

______________________________ ______________________________
Signature of Health Care Provider Date

Provider's name: ____

Business address: ____________________ ____________ ______ ________
Street City State Zip Code

Type of practice / Medical specialty: ______________________________________

Telephone: (_______)______________________ Fax: (________)________________________

Serious Health Condition

"Serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

☐ Hospital Care: Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity (e.g. an inability to work or perform other regular daily activities) 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:

i) 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 (e.g. physical therapist) under orders of, or on referral by, a health care provider; or
ii) 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: A period of incapacity due to pregnancy or for prenatal care.

☐ Chronic Conditions Requiring Treatment: A chronic condition which:

i) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under the direct supervision of a health care provider;
ii) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
iii) 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 that 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 continuous 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.

☐ 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 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 calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

Definition of Terms:

Incapacity for the 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 therefore, or recovery there from.

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. 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.