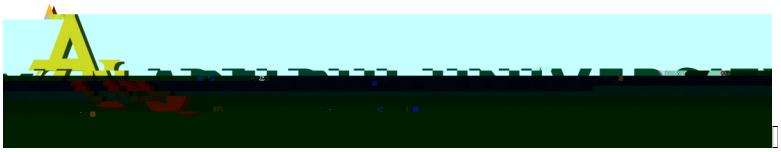


CERTIFICATION OF HEALTH CARE PROVIDER
(Family and Medical Leave Act of 1993)

PART A:

1. Employee's Name:_____

2. Patient's Name (if other than employee):_____

*** <u>The Genetic Information Nondiscrimination Act of 2008 (GINA)</u>:**

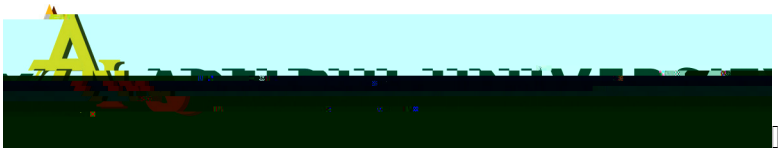
- *¯he ene c nfor on Nond scr n on Ac of NA proh s e p oyers nd o her en es co_ered y, NA¯ e fro reques ng or requ r ng gene c nfor on of n nd_du or f y e er of he nd_du e cep s spec f c y o ed y h s ¯o co p y h h s e re s ng h you no pro_de ny gene c nfor on hen respond ng o h s reques for ed c nfor on ene c nfor on s def ned y NA nc udes n nd_du s f y ed c h s ory he resu s of n nd_du s or f y e er s gene c es s he f c h n nd_du or n nd_du s f y e er sough or rece_ed gene c ser_ces nd gene c nfor on of fe us c rr ed y n nd_du or n nd_du s f y e er or n e ryo fu y he d y n nd_du or f y e er rece_ng ss s _e reproduc _e ser_ces*

3. Diagnosis:_____

4. Is the medical condition pregnancy? If yes, estimated delivery date:_____

5. Date condition commenced:_____

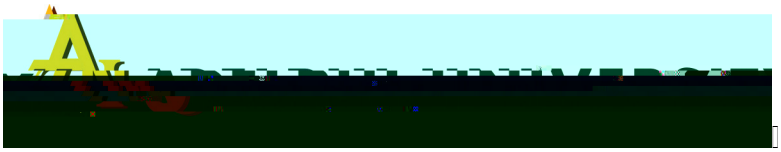
6. Probable duration of condition:_____



If this certification relates to care for the employee, complete items 8, 9, 10 and 11. For certification relating to seriously ill family member, complete items 12 through 14.

Check Yes or No in the boxes below, as appropriate:

	Yes	No
Employee		
8. Is in-patient hospitalization of the employee required?		
9. Is employee able to perform work of any kind? (If NO, skip item 10).		
10. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee).		
11. Will patient have to have treatment at least twice a year due to the condition?		
Family Member		
12. Is in-patient hospitalization of the family member (patient) required?		
13. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?		
14. After review of the employee's signed statement is the employee's presence necessary or beneficial for the care of or th59027le		



PART B: AMOUNT OF LEAVE NEEDED

1. 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? _____ No _____ Yes

- If so, estimate the beginning and ending dates for the period of in capacity:_____

2. Will the employee need to attend follow-up trea