STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
WAGE STANDARDS DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 340, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR HFLL-1 HAWAII FAMILY LEAVE CERTIFICATION OF SERIOUS HEALTH CONDITION

Instructions

Please completely fill out the HFLL-1 HAWAII FAMILY LEAVE CERTIFICATION OF SERIOUS HEALTH CONDITION.

Please remember to sign and date the form before submitting it.

This is an optional form to be completed by the health care provider and returned to your employer.

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(Rev. 10/05)

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HFLL-1 HAWAII FAMILY LEAVE CERTIFICATION OF SERIOUS HEALTH CONDITION

Under Chapter 398, Hawaii Revised Statutes, an employee is entitled to family leave to care for a child, parent, spouse or reciprocal beneficiary with a serious health condition. This optional form may be used by employees to satisfy a requirement to furnish a medical certification (when requested) from a health care provider. The form, to be filled out and signed by the Health Care Provider of the patient with a serious health condition, should be returned to the employee to submit to their employer to certify the serious health condition.

1. Employee's Name	2. Patient's Name
3. The last 2 pages describe what is meant by a **"serious health condition"** under the Hawaii Family Leave Law. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category. ☐ (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6), or ☐ None of the above	
4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria for one of these categories:	
5.a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity,**[2] if different):	
b. Will it be necessary for the employee to work only **intermittently or on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?	
If yes, give the probable duration:	
c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]:	

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking leave under the Hawaii Family Leave Law.

[2] "Incapacity," for purposes of Hawaii Family Leave Law, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment, or recovery.

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6.a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. 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:

c. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. The relationship of the patient with a serious health condition to the employee is:
- ☐ Spouse ☐ Reciprocal beneficiary
- ☐ Parent (including biological parent, foster parent, adoptive parent, parent-in-law, stepparent, legal guardian, biological or adoptive grandparent, or biological or adoptive grandparent-in-law)
- ☐ Child (including a biological, adopted, or foster son or daughter; a stepchild; or a legal ward of the employee)

8.a. If leave is required to **care for a child, parent, spouse or reciprocal beneficiary** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs, safety, or transportation?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider	Type of Practice
Print Name	Title
Address	
Telephone Number ( )	Date

To be completed by the employee requesting family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently, or if it will be necessary for you to work less than a full schedule:

Employee Signature Date

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A **"Serious Health Condition"** means a physical or mental condition that warrants the participation of the employee to provide care during the period of treatment of supervision by a health care provider and 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[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment
   (a) A period of incapacity[2] of **more than three (3) consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:
   (1) **Treatment**[3] **two (2) 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
   (2) **Treatment** by a health care provider on **at least one (1) occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. Pregnancy
   Any period of incapacity[2] due to **pregnancy** or **prenatal care**.

4. Chronic Conditions Requiring Treatments
   A **chronic condition** which:
   (1) 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;
   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
   (3) May cause **episodic** rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision
   A period of **incapacity**[2] 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) 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**[2] **of more than three (3) 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).

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[2] "Incapacity," for purposes of Hawaii Family Leave Law, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment, or recovery.

[3] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[4] 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. 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.