**Subsection C: Must be completed for all reduced scheduled leaves:**

1. Is it **medically necessary** for the employee to work part-time or a reduced schedule because of the employee's condition? (this includes follow up treatment appointments) ☒ No ☐ Yes

   If yes, estimate the part-time or reduced work schedule the employee needs:

   _____ hour(s) per day _____ time(s) per week _____ time(s) per month Start date: _____ End date: _____

**(Form is considered incomplete/insufficient if not provided for a reduced/part-time leave)**

**Subsection D: Must be completed for all intermittent leaves:**

1. Will the employee need intermittent time off? ☐ No ☒ Yes

   If yes, estimate the beginning and ending dates for the period the patient needs to be out of work:

   Start date: 2/13/24 End date: 2/13/25 Extension From Previous Leave

2. **OFFICE VISITS/TREATMENTS:**
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of follow-up treatments/office visits that employee would need off work for related incapacity that the employee may experience over the next 6 months.

   (e.g. Duration: _____ hours per visit/treatment
   Frequency: _____ times per _____ week(s) / month(s) (circle one))

   **Duration:** 5 hours per visit/treatment
   **Frequency:** 3 times per 1 week(s) / month(s) (circle one)

   **Form is considered incomplete/insufficient if not provided for an intermittent leave**

3. **INCAPACITY:**
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of incapacity that employee would need off work over the next 6 months.

   (e.g. Duration: _____ hours per day or _____ days per episode
   Frequency: _____ times per _____ week(s) / month(s) (circle one))

   **Duration:** 5 hours per day or _____ days per episode (every Tue/Thurs/Sat)
   (on Tues/Thur/Sat)
   **Frequency:** 3 times per 1 week(s) / month(s) (circle one)

   **(Form is considered incomplete/insufficient if not provided for an intermittent leave)**

**ADDITIONAL INFORMATION** _____

E Sweeney 2/14/24

**Signature of Health Care Provider** **Date:**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**
If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. The U.S. Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210.
**DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

*PLEASE BE SURE TO RETURN ALL PAGES

Return completed certification form to:

**NYL GBS Leave Solutions**
**Email: AbsenceManagement@newyorklife.com**
**Fax: 866.472.3221**
**P.O. Box 81077 Cleveland, OH 44181**