Family and Medical Leave Act (FMLA) Certification Form
Instruction Sheet

I. **Please review the instruction sheet (pages 1 & 2) and the Employee Information Sheet (pages 3 & 4).** If you have questions, contact your local FMLA Coordinator or the Absence and Return Center (ARC) at 817-967-6700. Detailed information regarding the FMLA policy is on Jetnet.

II. **Log onto Jetnet to ensure the accuracy of your permanent and alternate mailing addresses on file.**

III. **In order to have FMLA Leave designated, you must be both administratively and medically eligible and submit the required documentation within the administrative timelines.**

A. **Employee Administrative Eligibility:** You are administratively eligible for FMLA Leave if:

1. You have at least 12 months of company service as of the actual start date of the leave and,
2. You have worked at least 1,250 hours during the 12-month period immediately preceding the start of the requested leave.
   a. Hours worked do not include vacation, paid sick, holidays, injury on duty time, crew layover time, leave time, etc.
   b. Pilots and Flight Attendants must have worked or been paid for not less than 60 percent of the applicable monthly guarantee and worked or been paid for not less than 504 hours excluding sick or medical leave or vacation time during the previous 12-month period.

B. **Employee Administrative Timelines:**

1. If your need for leave is foreseeable, you must notify your supervisor at least 30 calendar days in advance of the date on which your FMLA leave will begin. If 30 days' notice is not practicable, such as because of a lack of knowledge of approximately when leave will be required to begin, a change in circumstances, or a medical emergency, notice must be given as soon as practicable (generally within 2 business days of learning of the need for leave).
2. If your need for leave is *unforeseeable*, you must notify your supervisor of your need for FMLA leave as soon as practicable and in compliance with your department's usual and customary requirements for calling off of work, absent unusual circumstances.
3. Employees must provide sufficient medical certification of the need for leave to the Company within 17 calendar days of the date on which such certification is requested by the Company, absent extenuating circumstances.
   a. If the submitted medical documentation requires additional information or clarification, you will be notified and given an opportunity to provide the additional information to the ARC within 15 additional calendar days.
   b. Be sure the treating health care provider is aware of the deadlines you have been given.

C. **Medical Eligibility** – You are medically eligible for FMLA Leave if:

1. You are requesting FMLA Leave for yourself or an eligible family member and,
2. It is medically necessary for you to take time away from work for the serious health condition and,
3. The serious health condition meets one of the six categories defined in the FMLA Federal Regulations
4. **Incapacity:** For the purposes of FMLA Leave, incapacity is defined as the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

IV. **Complete the FMLA Certification Form on pages 5 – 7 (and page 8 if needed)**

A. **Section A** – Items 1 through 6 – to be completed by you, the employee.

B. **Section B** – Items 7 through 19 – To be completed only by the health care provider treating the serious health condition for which you are requesting the FMLA Leave. Do not make alterations to the information documented by the treating health care provider. Your health care provider may need a copy of your Essential Job Functions. (Please contact your local supervisor if required). If the leave is for an Adult Child, the health care provider treating your child must complete Section B of this document and Section C.

C. **Section C** – To be completed by the health care provider treating your child if your FMLA Leave is needed to provide care for a child age 18 or older. Do not make alterations to the information documented by the treating health care provider.

V. **Submit the FMLA Certification Form**

A. Fax completed pages 5 – 7 (and page 8 if needed) to the ARC: 1-855-709-4903. Write your name and employee number on the BACK of each page. Keep the transmittal sheet of your fax.

B. Mail pages 5 - 7 (and page 8 if needed) to ARC, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616. Keep the mail receipt.
Note: It is your responsibility to ensure American Airlines ARC receives the completed FMLA Certification Form.

Family and Medical Leave Act (FMLA) Certification Form
Instruction Sheet (continued)

VI. **Verify the status of your FMLA**

A. Check the status of your leave request on Jetnet. Select "Team Member Services", then select "Leaves and Returns" under FMLA select applying for Leave". Click on "Check FMLA Status" under item four. If there is not a current case, then the ARC has not created a case for you.

B. If ARC has not created a case for you within 3 business days from the fax date, then ARC did not receive your form. Resend your completed form and ensure you keep your fax confirmation sheet.

C. If ARC requests additional information, be sure the treating health care provider is aware of the deadlines you have been given.

VII. **Designated / Not designated FMLA leave -** After your FMLA form is submitted, your leave will either be 'Designated' or 'Not Designated'.

A. **Designated:** Your specified time away from work is designated for FMLA Leave.

B. **Not Designated:** Your specified time away from work is not designated for FMLA Leave.

VIII. **Type of FMLA Leave -** FMLA Leave may be taken as a Regular / Block, Intermittent, or Reduced Schedule leave. (Note the difference below)

A. **If you are requesting FMLA Block Leave:**

1. **FMLA Block Leave** – a one-time continuous leave for a serious health condition. Some collective bargaining agreements (CBAs) provide for a Medical/Sick Leave of Absence if you are in need of a block leave for your own condition and all Sick/Medical eligibility criteria are met. The company will require such leave to run concurrently with FMLA leave.
2. Absences that do not fall between the designated start and end dates of your designated leave will not be coded as FMLA or Sick/Medical leave and may be considered an attendance occurrence under the applicable attendance policy.
3. Returning to work prior to the end date of your designated block leave will end your leave. New medical certification will need to be provided if you are in need of a new block leave after having returned to work from your designated leave.
4. If you need to extend the designated end date of your block leave, it is your obligation to provide notice to the Company of the requested extension as soon as practicable (typically within 2 business days of learning of the changed circumstances). After receiving notice of a requested leave extension, the Company may require you submit a new medical certification completed by the appropriate health care provider. That certification must be provided to the Company within 17 calendar days of the date on which such certification is requested by the Company, absent extenuating circumstances. Failure to provide timely notice and/or proper certification of any leave extension may cause a lapse in your leave coverage.

B. **If you are requesting Intermittent FMLA Leave or a Reduced Leave Schedule:**

1. **Intermittent FMLA Leave** – leave taken in separate blocks of time for a single qualifying reason.
2. **Reduced Leave Schedule** - a leave schedule that reduces the usual number of working hours per workweek, or hours per workday *(Example: your health care provider indicates that you should only work 4 hours per day for 6 weeks due to your health condition.)*
3. When using Intermittent FMLA leave or a Reduced Leave Schedule, you must advise your supervisor of the need for leave as soon as practicable under the circumstances. Please be advised that you must comply with your department's usual and customary requirements for calling off of work, absent unusual circumstances.
4. Employees needing intermittent FMLA Leave or a Reduced Leave Schedule must attempt to schedule their leave so as to not disrupt the operation. This includes, but is not limited to, scheduling appointments with the health care provider, therapy sessions, medical procedures, etc., at times when you are not scheduled to be at work. You may be reassigned to an alternative position with equivalent pay and benefits that better accommodates your forseeable intermittent or reduced leave schedule.

Family and Medical Leave Act (FMLA) Certification Form
Employee Information

Annual Amount of FMLA Leave
You may take a maximum of 12 workweeks of FMLA Leave per rolling calendar year. If your request has been designated as FMLA Leave, this leave will count against your annual FMLA Leave allotment. If you have FMLA Leave designated for a family member who was a service member injured/ill in the line of duty, your FMLA allotment cannot exceed a maximum of 26 weeks in a rolling 12-month period. All designated FMLA Leave usage, for all conditions, will count against your annual FMLA Leave allotment.

Attendance Policy
Absences that do not fall between the designated start and end dates, or absences for other reasons will not be coded as FMLA Leave and may be considered an attendance occurrence under the applicable attendance policy.

Benefit Coverage
While you are on FMLA Leave, you are still responsible for any employee premiums for any employee benefits at the same rate you paid while actively working. If your FMLA Leave is paid, these contributions will continue to be deducted from your paycheck. If your FMLA Leave is unpaid and you have been removed from payroll, subsequent payments need to be made by the due date indicated on your monthly payment notice sent by Aon Hewitt. You will receive detailed benefit information in the mail which will explain how to make payments during your unpaid FMLA Leave. If you do not receive benefit information within 10 days of starting your unpaid FMLA Leave, please call the **Benefits Center at: 1-888-860-6178**. It is your responsibility to ensure that benefit premiums are being paid while you are on leave. If you fail to pay for optional coverage(s) such as life insurance and disability, your coverage may lapse.

Birth/Adoption/Foster Placement
You are required to provide certification of birth, adoption or foster care placement by submitting Section A and one of the 3 following items: 1) estimated due date, 2) date of birth, or 3) documentation of the adoption or foster care placement of the child.

Job Restoration
You are entitled to your same or an equivalent job in your current location at the end of your FMLA Leave. Your rate of pay will be determined by company policies in effect at the time of your return.

Life Event
An unpaid leave of absence is considered a Life Event that allows you to make changes to your benefit plan in accordance with the plan provisions.

Misrepresentation
Misrepresentation of any kind in your application for and/or use of FMLA Leave is a direct violation of company policy, and you may be subject to corrective action, up to and including termination.

Paid Holidays
Absences during a holiday on which you were originally scheduled to work do not generally qualify for holiday pay. Please refer to your Collective Bargaining Agreement and/or any applicable policies to determine if you will be eligible for holiday pay during a FMLA-related absence.

Paid Leave Substitution
Unless otherwise stipulated by an applicable collective bargaining agreement, American Airlines requires the use of certain paid leave concurrently with your FMLA Leave. Employees are advised to check their workgroup specific policies and/or Collective Bargaining Agreement.
** Certain state laws may allow you to use a portion of your available paid sick time when providing care to an eligible family member.*

Paid Work While on FMLA Leave
Paid work (including any self-employment) while on FMLA leave at American Airlines is not permitted without prior written approval from the company. If you receive pay for work without prior approval you will be considered to have resigned from the Company.

Reduction in Force
FMLA Leave does not protect you from layoff. An employee who would be laid off while active can still be laid off while on FMLA Leave.

Return to Work Certification Requirements
If you meet the Company's return to work criteria, then prior to returning to work you will be required to provide the Company with a written certification from your treating healthcare provider stating that you can perform the essential functions of the job. If you need to provide a return to work certification, you will receive notice from the Company and will be provided with the return to work certification form that must be completed by your health care provider. Should you fail to provide the required return to work certification prior to your scheduled return to work, then your return to work may be delayed or denied.

State and Municipality Laws
Certain states or municipalities may have their own laws regarding similar types of family care or medical leave. To the extent consistent with applicable law, FMLA designated absences will count toward an employee's allotment of time off under state or local laws that provide time off for personal illness or the care of a sick family member.

Spouse
A legally married couple. The FMLA defines a "spouse" as a husband or wife as defined or recognized under State law for purposes of marriage in the state where the marriage was entered into, including common law marriage in states where it is recognized. This definition applies to all legally married couples regardless of gender or state of residence.

Domestic Partner (DP)
The federal FMLA does not include Domestic Partner (DP) as an eligible family member. However, the Company will include same-sex DP as an eligible family member if the employee has complied with the requirements of the Company's Domestic Partner Program.

Travel Privileges
Travel privileges for domestic employees while on an approved leave of absence are determined by the type of leave. Please refer to the travel sections on Jetnet and Wings for additional details.

Family and Medical Leave Act (FMLA) Certification Form
Employee Information (continued)
Questions and Answers about FMLA Leave

Q1. How soon should I notify the Company that I need to take FMLA Leave?

A1. If your need for leave is foreseeable based on an expected birth, placement for adoption or foster care, planned medical treatment for a serious health condition of the employee or of a family member, or the planned medical treatment for a serious injury or illness of a covered servicemember, you must notify your supervisor at least 30 calendar days in advance when you plan to use any type of FMLA Leave of the date on which your FMLA leave will begin. If 30 days' notice is not practicable, such as because of a lack of knowledge of approximately when leave will be required to begin, a change in circumstances, or a medical emergency, notice must be given as soon as practicable (generally within 2 business days of learning of the need for leave).

If your need for leave is unforeseeable, you must notify your supervisor as soon as practicable and in compliance with your department's usual and customary requirements for calling off of work, absent unusual circumstances. Employees must provide sufficient medical certification of the need for leave to the Company within 17 calendar days of the date that such certification is requested by the Company, absent extenuating circumstances.

Q2. Can I verify that the Absence and Return Center (ARC) received my application for FMLA Leave?

A2. You can check the status of your FMLA request on Jetnet.

Q3. My doctor's office says they faxed my application, but the Absence and Return Center didn't receive it. What should I do?

A3. Call the health care provider's office and find out who handles the administrative tasks such as faxing medical documents. Ask this person to send the information again either via fax or U.S. Mail. If the form is sent via fax, ask them to keep a copy of the confirmation page. If they send it via U.S. Mail, ask them to maintain a copy of the application in your medical record. Be sure your health care provider's office understands the timelines by which your application must be received. Timeline extensions will not be granted, absent exigent circumstances.

Q4. Should I keep a copy of my FMLA application after the health care provider completes his/her portion?

A4. Absolutely! You can check the status of your FMLA request on Jetnet.

Q5. My doctor's office charges me a fee to complete the paperwork and fax it to the Absence and Return Center. Who should I send the bill to?

A5. AA is not responsible for this cost. If your health care provider charges a fee for completing or faxing the FMLA application, it is your responsibility to pay for the services. To minimize your costs, be sure the form is completed fully the first time. You should discuss your needs with the health care provider prior to having the FMLA forms completed.

Q6. My doctor did not answer one of the questions on the FMLA Certification Form. Can I answer it myself?

A6. No. Do not answer any of the questions on Section B or Section C of the FMLA Certification Form. This is considered misrepresentation and may result in corrective action, up to and including termination.

Q7. The Absence and Return Center has indicated that my doctor did not answer questions 17a and 17b on the request for intermittent FMLA Leave. I contacted my doctor and asked him to provide the information, but he said, "I can't answer that because I can't predict when you are going to be too sick to go to work." What should I do?

A7. Questions 17a and 17b ask the health care provider to provide an estimate of the frequency and duration under which you may need to take intermittent FMLA Leave. This is not a "prediction" of when you will be ill. However, the health care provider must review the prior medical history of this health condition and estimate how often it typically causes you to become incapacitated and how long each episode typically lasts. For example, in the past, you may have become physically incapacitated once every two months, and each episode may have lasted anywhere from 1 day to 3 days. In addition, based on your history, you routinely follow-up with your health care provider for this condition about once every 3 months. These are the kinds of facts that should be provided, and they should be based only on your current medical need for leave.

Q8. The Absence and Return Center (ARC) has asked the health care provider to submit additional medical facts to support the medical necessity of the intermittent FMLA Leave. What does this mean?

A8. This means that your health care provider should document the medical facts to support your request for FMLA Leave. For example, your physician has documented that you need to take off twice a month, 2 to 3 days each time for the next six months for "leg pain". Additional medical facts to support your need for leave may include items such as symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, any referrals for evaluation or treatment (physical therapy, for example), or any other regimen of continuing treatment.

Q9. I have a lot of questions about FMLA Leave. Where should I go for answers?

A9. If you have questions regarding the FMLA leave request process or need information regarding the company FMLA policy, log onto Jetnet. If you have questions that are not answered by the FMLA policy, contact your supervisor or FMLA coordinator. You may also contact the Absence & Return Center at 817-967-6700.

Family and Medical Leave Act (FMLA) Certification Form

Section A – Completed by the Employee

1. ______________________ ______________________ ______________ ________
First Name Last Name AA Employee # Base

____ ______________________
Email Address Phone Number

Your Job:

O Admirals Club	O Cargo	O Flight Attendant	O Planner
O Agent	O Credit Union	O Fueler	O Reservations
O Aircraft Mechanic	O Facilities Maintenance	O Management	O Support Staff
O Auto Mechanic	O Fleet Service - Ramp	O Pilot	O Other: ___________

In the past seven years have you:

O Yes O No Been on military leave?

O Yes O No Worked as a contractor or temporary employee for American Airlines?

2. **Are you requesting this FMLA leave for your own serious health condition?**

O Yes O No If No, this leave is to provide care for my:

O Baby Bonding*	O Son	O Father	O Spouse	O Adoption / Foster Placement*
O Birth*	O Daughter	O Mother	O Domestic Partner	O Other: ___________

* You are required to provide certification of birth, adoption or placement by submitting Section A and one of the following: 1) Estimated due date, 2) date of birth or 3) documentation of the adoption or foster care placement of the child.

______________________ ______________________ ______________ ______
Family Member's First Name Family Member's Last Name Date of Birth Age

3. **For baby bonding**- please provide the start and end dates for the bonding period (must take place within 12 months following the birth):

Start Date: ______________ End Date: ______________

4. **Notification** - Please print your supervisor's first and last name below:

__________________________ __________________________
Supervisor's First Name Supervisor's Last Name

5. **Acknowledgement -** By signing this document I acknowledge that:

- I have received, read and understand all pages of this document.
- I can check the status of my FMLA leave on Jetnet.
- I have not made or will not make any alterations to the information documented by the treating healthcare provider.
- I have not completed any of the questions of Section B, which is to be completed only by the treating health care provider.
- An ARC representative may need to contact my treating health care provider to clarify or authenticate this form and has permission to do so.
- I affirm that both my permanent and alternate mailing addresses on the file with the company are accurate.
- It is my responsibility to ensure this completed form and any additional information requested at a later date is submitted to and received by the ARC via fax or U.S. mail within the administrative timelines listed on page 1.
- Misrepresentation of any kind in my application for and/or use of FMLA are subject to corrective action, up to and including termination.

____ ______________
Signature Date

6. **Submitting the completed form** – You must fax or mail the completed form to the Absence & Return Center (ARC). By fax – write your name and employee number on the back of each page, fax the completed form to the ARC and retain your fax transmittal sheets or mail to the Absence and Return Center's address below. **Your FMLA leave status will be updated on Jetnet within two business days from the date it is received.**

Fax completed form to 1-855-709-4903 or mail to: Absence & Return Center, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616

Family and Medical Leave Act (FMLA) Certification Form

Section B – Completed by the Patient's Health Care Provider

________________________________ ___________________________________ ___________________ __________
First Name Last Name AA Employee # Base

GINA Notice: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers 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.

Items 7-19 MUST be completed by the treating health care provider to provide American Airlines with a confidential certification of your patient's health conditions. Questions 7-12 correlates with federal FMLA regulations for Serious Health Condition criteria. <u>You must answer YES or NO to each question below. All YES answered questions must be completed in full.</u>

7. ○ Yes ○ No The patient is/has/will be admitted for an overnight stay in a hospital, hospice or residential medical care facility.

   Dates of overnight stay: _____ / _____ / _____ through _____ / _____ / _____

8. ○ Yes ○ No The patient is/has/will be **incapacitated** for more than 3 consecutive calendar days and had an in person visit within seven days of the first day of incapacity and (check one):

   ○ At least one additional treatment within 30 days of the start of the incapacity OR
   ○ Treatment* by a health care provider on at least one occasion which results in a Regimen of Continuing Treatment**. (example: prescription medication, therapy)
   *Treatment - **does not include** routine physical, eye or dental examinations.
   Regimen of Continuing Treatment – **does not include activities that can be initiated without a visit to a health care provider (example: over the counter medications, bed rest, drinking fluids or exercise)

9. ○ Yes ○ No The patient is pregnant.

   ○ Actual ○ Expected Delivery Date: _____ / _____ / _____

10. ○ Yes ○ No The patient ***is/has/will*** be incapacitated and out of work to receive treatment for a chronic or serious health condition which results in at least two in-person office visits per year and which causes episodic or continuing incapacity (example: asthma, diabetes, epilepsy)

11. ○ Yes ○ No The patient ***is/has/will*** be incapacitated by a permanent or long term condition for which patient is undergoing continuing treatment or supervision (example: Alzheimer's, severe stroke, terminal stages of a disease)

12. ○ Yes ○ No The patient ***is/has/will*** be incapacitated and will receive/received multiple treatments for a non-chronic condition (example: chemotherapy, radiation, physical therapy, dialysis)

13. ○ Yes ○ No The employee is requesting leave to care for a family member and their presence is necessary to provide physical and/or psychological benefits for your patient.

    If yes, describe care employee will provide for patient: ____

14. Please describe the medical facts for this condition to substantiate the employee's time away from work. This may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, any referrals for evaluation or treatment (physical therapy, for example), or any other regimen of continuing treatment. Please be aware that headaches (other than migraines), and infertility treatment or cosmetic procedures (unless overnight inpatient hospital care or complications develop) are not covered as FMLA.

____

____

____

____

14A. Last two office visits if applicable _______/_______/_______ _______/_______/_______

15. For chiropractic use only

    ○ Yes ○ No The patient is/was treated by manual manipulation of the spine.

    ○ Yes ○ No Subluxation of the spine has been demonstrated to exist by current or previous x-ray imaging.

Fax completed form to 1-855-709-4903 or mail to: Absence & Return Center, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616

American Airlines

Family and Medical Leave Act (FMLA) Certification Form

Section B – Completed by the Patient's Health Care Provider

First Name ________________	Last Name ________________	AA Employee # ________	Base ______

Questions 16-18, enter the start and end dates of the appropriate type(s) of FMLA leave in the columns below that apply for your patient's condition.. The medical facts (question 14) on this form must substantiate the type(s) and length of leave requested.

16. **Regular/Block –** is indicated when the employee is incapacitated and requires a single block of time away from work due to the serious health condition.

Dates of incapacity are:

Start Date: _____ / _____ / _____

End Date: _____ / _____ / _____

Please note, the dates of incapacity are not necessarily the dates of absence from work (e.g. trip sequence or scheduled work days).

17. **Intermittent –** is indicated when the employee requires intermittent periods of time away from work due to the serious health condition.

Start Date: _____ / _____ / _____

End Date: _____ / _____ / _____

Must complete A and B

A. Frequency of leave:

_____# times/episodes per: *(select only one)*

- ○ year
- ○ month, or
- ○ week

B. For a duration of: *(select only one)*

______# hours, or

______# day(s) per episode

> ***Example:*** *4 times/episodes per year lasting 1-2 days each time*
>
> ***A. Frequency of Leave:***
>
> *__4__ # times/episodes per:*
> - ● *year*
> - ○ *month*
> - ○ *week*
>
> ***B. For a duration of:***
>
> *______# hours, or*
>
> *__1-2__# day(s) per episode*

18. **Reduced-schedule** – is indicated when the employee requires a reduced number of hours of daily work due to the serious health condition.

Start Date: _____ / _____ / _____

End Date: _____ / _____ / _____

Approximately how many hours per day/week should the employee work?

____# hours per day

Reduced-schedule FMLA does not apply to Pilots or Flight Attendants.

19. **Treating Health Care Provider Information**

Name (Please print) ________________________ License # ________________

Type of practice ________________________ State (location) of practice ________________

Office phone # ________________ Office fax # ________________ Best day/time to contact ________________

By signing this form, you are certifying that you are the treating health care provider for this condition and you agree that the American Airlines employee will need to take time off from work under the FMLA for a serious health condition.

Treating Health Care Provider's Signature ________________________ Today's Date _____ / _____ / _____

Fax completed form to 1-855-709-4903 or mail to: Absence & Return Center, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616

Family and Medical Leave Act (FMLA) Certification Form

Section C – Completed by the Patient's Health Care Provider

Only Complete for the Care of an Adult Child

________________________________ ___________________________________ ___________________ __________

First Name Last Name AA Employee # Base

FMLA Leave may be taken to provide care for a son or daughter age 18 or older if that child is incapable of self-care because of a mental or physical disability.

Definitions

- Son or Daughter – a biological, adopted, foster, step-child, a legal ward, or a child of a person standing in loco parentis, who is either under age 18, or age 18 and older and incapable of self-care because of a mental or physical disability.
- Incapable of self-care – the individual requires active assistance or supervision to provide daily self-care in three or more of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs). ADLs include adaptive activities such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating. IADLs include cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, using a post office, etc.
- Physical or Mental Disability – a physical or mental impairment that substantially limits one or more of the major life activities of an individual.

To be completed by the Adult Child's Treating Health Care Provider for this Condition

____ ____

Patient's First Name Patient's Last Name

Please **check all** of the boxes next to the ADLs and/or the IADLs which require the employee to assist his/her adult child:

☐ Bathing	☐ Hygiene	☐ Other: (Please List)
☐ Cleaning	☐ Medical Care	____________________
☐ Cooking	☐ Paying Bills	____________________
☐ Dressing	☐ Shopping	____________________
☐ Eating	☐ Taking Public Transportation	____________________
☐ Grooming	☐ Using Telephones and Directories	____________________

20. **Treating Health Care Provider Information**

____ ______________________________________

Name (Please print) License #

____ ______________________________________

Type of practice State (location) of practice

______________________________________ ______________________________________ _______________________

Office phone # Office fax # Best day/time to contact

By signing this form, you are certifying that you are the treating health care provider for this condition and you agree that the American Airlines employee will need to take time off from work under the FMLA for a serious health condition.

____ _____ / _____ / _____

Treating Health Care Provider's Signature Today's Date

Fax completed form to 1-855-709-4903 or mail to: Absence & Return Center, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616