NOT MEASUREMENT SENSITIVE

DOE G 341.1-1
12-1-03

GUIDE
ON FEDERAL EMPLOYEE OCCUPATIONAL MEDICAL PROGRAMS

[This Guide describes suggested nonmandatory approaches for meeting requirements. Guides are not requirements documents and are not to be construed as requirements in any audit or appraisal for compliance with the parent Policy, Order, Notice, or Manual.]

U.S. DEPARTMENT OF ENERGY
Director of Human Resources Management

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All Departmental Elements

INITIATED BY:
Office of Human Resources Policy and Planning

GUIDE ON FEDERAL EMPLOYEE OCCUPATIONAL MEDICAL PROGRAMS

INTRODUCTION

1. PURPOSE. This Guide supplements the requirements and responsibilities specified in DOE O 341.1, *Federal Employee Health Services*, dated 12-1-03. This Guide provides preferred implementing methods and procedures. The provisions in this Guide are intended for all levels of personnel involved in managing and/or operating health units/clinics or contracting for occupational medical services.

   DOE Guides provide supplemental information for fulfilling requirements contained in rules, Orders, Notices, and regulatory standards. Guides are also used to identify Government and non-Government standards and methods DOE finds acceptable for implementing the Department's requirements. Guides are not substitutes for requirements nor do they replace technical standards, which are used to describe established practices and procedures for implementing requirements.

2. CONTACT. Questions concerning this Guide should be addressed to the Office of Human Resources Policy and Planning at 202-586-8503.

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CHAPTER I. BACKGROUND

The Department of Energy (DOE) recognizes that healthy employees are more productive and, as a result, reduce costs to the Government. Accordingly, DOE is committed to providing work-related medical services for preventive, diagnostic, and treatment purposes to the extent such services can be provided cost effectively.

The type and extent of occupational medical services for Federal employees varies depending on available resources such as funds, personnel, and equipment at or near the work site. Every effort should be made to provide or contract for quality comprehensive services.

Medical support staffs are expected to—

- know the work environment and organization served,
- demonstrate a caring attitude about employees,
- treat or refer for treatment (as determined by a qualified health services professional) employees who incur injuries or illnesses while on the job, and
- monitor employees who undergo treatment or rehabilitation to ensure they receive appropriate care, actively participate in treatment or rehabilitation, and return to duty as soon as possible.

The following services should be given priority:

- assistance in identifying of positions with hazardous exposures or the potential for them,
- examinations and medical surveillance of employees exposed to hazardous conditions,
- fitness-for-duty examinations, and
- emergency first aid.

Cases that need in-depth attention and should be managed include those involving hazardous exposure, employee relations, a medical issue, and workers' compensation.

Occupational medical services should be available within a reasonable time to respond to emergencies. "Reasonable time" is based on the work site location and resources available in that area, which affect the time required for medical assistance to arrive at the work site.

Occupational medical services programs are to be evaluated periodically (see Chapter VIII of this Guide) by medical professionals with thorough knowledge of occupational medicine and the work environment [DOE O 341.1, *Federal Employee Health Services,* dated 12-1-03, paragraph

4a(3)]. Evaluation reports are to be provided to top managers in the DOE element being evaluated and to applicable Headquarters program managers. Managers at both levels should have sufficient authority to ensure that agreed-upon recommendations and required actions are implemented.

CHAPTER II. ROLES AND RESPONSIBILITIES

1. SUPERVISORS. With the exception of workers' compensation cases, determining whether a Federal employee is "fit for duty" is a collaborative process involving the employee's supervisor(s), the medical support staff, and the human resources staff. Supervisors are responsible for making the final determination as to whether the employee will perform assigned duties (see Chapter IX, paragraph 2b, of this Guide regarding the medical information that a supervisor should be provided to make such determinations).

   a. Supervisors can require that a medical evaluation/fitness-for-duty examination be given only if—

      (1) the employee's position requires that the employee meet medical standards, i.e., psychological and/or physical standards, or the position is covered by a medical evaluation program, such as the DOE medical surveillance program, or

      (2) the employee is applying for, or is covered by, the workers' compensation program.

      [See 5 CFR Part 339, Subpart B; Section VI, "Medical Requirements," of the U.S. Office of Personnel Management (OPM) operating manual, *Qualifications Standards for General Schedule Positions,* dated 3-22-99; and any DOE standards established by the Director of Human Resources, NNSA Administrator, and/or the Assistant Secretary for Environment, Safety and Health.]

      For all other situations, the examination can only be offered.

   b. Supervisors, in conjunction with the human resources, industrial hygiene, and medical support staffs, play a principal role in identifying employees who may be exposed to hazards. Such exposures should be documented in position descriptions and reviewed at least annually.

2. HUMAN RESOURCES STAFF. The human resources staff is normally responsible for ensuring that adequate medical support is provided. If such services are contracted, the human resources staff usually prepares the purchase request for such services. Because the human resources staff needs to know which positions meet the medical requirements of the qualifications review process (in accordance with 5 CFR Part 339), the staff should actively participate in determining which positions are subject to hazardous exposures. The human resources staff should participate in the placement and accommodation of employees who are returning to work with impairments and should also participate in determining the employability of personnel following medical evaluations.

3. INDUSTRIAL HYGIENE STAFF. As experts in hazardous exposure, the industrial hygiene staff should help identify positions that are subject to hazardous exposures and determine whether such positions should be tracked in the DOE medical surveillance program.

4. MEDICAL OFFICER.

The role of the medical officer is to—

- determine employees' medical conditions and whether the employees are medically fit for duty, (except in workers' compensation cases as noted in paragraph 5 below);
- determine whether employees meet the medical requirements of their positions;
- determine the medical sufficiency/adequacy of any documentation provided by employees or their physicians to explain the nature and extent of their medical conditions;
- advise on the medical appropriateness of possible accommodations or propose alternative accommodations to those requested by employees;
- perform fitness-for-duty examinations for employees who are subject to medical evaluation (5 CFR, Part 339);
- determine the need for medical surveillance based on employee occupational exposure profiles, in response to regulatory requirements, or as a matter of best practice;
- advise supervisors and human resources staff on employees' medical conditions (i.e., their general fitness for duty and ability to work);
- work with employee assistance program (EAP) counselors and, when applicable, mental health providers to determine and resolve behavioral problems attributable to employees' physical conditions; and
- establish and maintain a medical surveillance program to track positions subject to the requirements of that programs.

5. DEPARTMENT OF LABOR. Fitness for duty for workers' compensation cases is determined by the U.S. Department of Labor's Office of Workers' Compensation based on input from the employee, the employee's physician, supervisors, the human resources and medical support staffs, and/or an Office of Workers' Compensation occupational nurse.

CHAPTER III. GETTING STARTED

1. RECOMMENDED ORIENTATION ACTIVITIES FOR THE FIRST QUARTER. A new health program manager—whether a director of administration, personnel officer, site medical director, or supervisor of a health unit—needs an orientation to the DOE Occupational Medical Program within the first quarter he/she occupies that position. The following is a checklist of orientation activities.

   a. Reading.

      (1) DOE O 341.1 (provides the framework and requirements for the program).

      (2) This Guide and DOE G 440.1-1, *Worker Protection Management for DOE Federal and Contractor Employees Guide*, dated 7-10-97.

      (3) *Standards and Criteria for the Development and Evaluation of Comprehensive Occupational Health Programs,* March 1990, Federal Occupational Health, Department of Health and Human Services (U.S. Government Printing Office number 1988-0-227-306).

      (4) Workforce profile and position descriptions of the medical support staff.

      (5) The program budget for the current and next fiscal years, if available.

      (6) The most recent evaluation reports and corrective action plans, if applicable.

      (7) Contracts and/or inter-Agency agreements of service providers, laboratories, etc., (immediate supervisors only).

      (8) Current OPM publications and Web site information (available at http://www.opm.gov/ehs/health3.asp).

   b. Consultations.

      (1) Medical support staff.

      (2) Employee relations staff in the servicing personnel/human resources office.

      (3) EAP counselor(s).

      (4) Local union representatives and labor relations staff, if applicable.

(5) Office of Human Resources Policy and Planning staff (Department level office).

(6) Office of the Assistant Secretary for Environment, Safety and Health.

2. RECOMMENDED ORIENTATION ACTIVITIES FOR THE FIRST YEAR. The following activities should prove beneficial to a new health program manager if accomplished within the first year the incumbent occupies the position.

a. Reading.

(1) All references cited in DOE O 341.1.

(2) *A Manual for the Comprehensive Management Evaluation of Occupational Health Programs,* issued by the former Public Health Service, Department of Health and Human Services (call 800-457-9808 for assistance in obtaining this document).

b. Consultations.

(1) The health program representatives at applicable OPM regional offices.

(2) The central point of contact for Federal Occupational Health (FOH), Department of Health and Human Services (see Appendix A and http://www.foh.dhhs.gov). That person will provide general information on FOH medical services and identify the nearest available clinic or appropriate staff to be contacted.

(3) Managers of the occupational medical programs in other Federal agencies or corporations in the area.

(4) The staff of the Institute of Medicine, National Academy of Science (telephone 202-334-2165; http://www.iom.edu/).

c. Education/Training. Every effort should be made to attend at least one seminar or conference, particularly the Department's conference.

(1) The Department's conference on health and safety, which is sponsored by the Office of Environment, Safety and Health (date varies).

(2) The American Association of Occupational Health Nurses (see http://www.aaohn.org/) national conference.

(3) The American Occupational Health Conference (see http://www.acoem.org/education/conferences.asp) national conference for physicians and nurses [the end of April or the first part of May)].

(4) OPM's national work/life/wellness programs and conferences (see http://www.opm.gov/ehs/index.asp).

(5) Occupational health reviews, updates, or clinical issues seminars, which are put on throughout the country by health professional associations.

CHAPTER IV. SERVICES, ACTIVITIES, AND/OR PROGRAMS

This chapter lists the services, activities, and/or programs that constitute an occupational medical program. The types of services, activities, and/or programs offered (indicated in the list below) vary among DOE elements. The asterisks (*) identify services that are normally provided by or for each DOE element.

- Allergy injections (provided a physician is present)
- Blood drives
- Cardiopulmonary resuscitation (CPR) training
- Case management*
- Consultations—employee and management*
- Dependent care (i.e., child care and elder care programs; these are normally administered by the human resources staff or EAP provider)
- Emergency response planning*
- EAP (for most DOE elements, the EAP for Federal employees is normally administered separately from the occupational medical program)
- Ergonomics*
- Examinations/medical evaluations/fitness-for-duty determinations*
- First aid training
- Fitness (aerobics, weights, weight control, etc.)
- Health fairs
- Health information/education/counseling*
- Health screenings*
- Identification of positions with hazardous exposures (in conjunction with program, industrial hygiene, safety, and human resources staffs)*
- Immunizations
- International travel assistance, including medical preparations for travel
- Marketing/promotion (of services/activities/programs offered)*
- Medical surveillance
- Nutritional counseling
- Orientation for new employees
- “Red Ribbon” campaign (regarding Drug-Free Workplace Program)
- Referrals for non-work-related medical treatment
- Risk and hazard communication*
- Wellness (an umbrella term that covers any combination of the above services, activities, and/or programs, including screening)
- Workers’ compensation claims*

CHAPTER V. MEDICAL TREATMENT

This chapter describes situations in which medical examinations and other medical treatment may be provided by the medical support staff.

1. EXAMINATIONS FOR EMPLOYEES IN POSITIONS WITH ESTABLISHED MEDICAL STANDARDS AND/OR HAZARDOUS EXPOSURES. All such medical examinations may be required by a supervisor (see 5 CFR Part 339, Subpart C) and are provided at no cost to the employee or applicant for employment.

   a. Preemployment/Baseline.

      (1) This is a general physical examination performed on a selected, prospective employee, whether selected from the outside or being transferred from one position to another within DOE, as part of the qualification process before employment or assignment to a position, to determine—

         (a) baseline information, including health status, on the applicant;

         (b) whether the applicant is likely to incur any problems performing the duties of the position; and

         (c) whether the applicant will need any accommodation to perform in the position.

      (2) The staffing specialist in the servicing human resources office should notify the prospective employee and medical support staff of the need to schedule the examination.

      (3) The examination should focus on the health and/or physical factors associated with the potential hazards/risks of the position; for example, a position that requires the use of lasers should focus on examination of the eyes.

   b. Periodic. This is a general physical examination to determine the health status of the employee in relation to a hazardous exposure(s) and provide early detection of any health or physical problems that may adversely affect the employee's work performance.

      (1) The examination should focus on the health and/or physical factors associated with the hazard(s) of the position.

(2) The frequency of the examination should be determined locally based on the frequency of or potential for exposures or applicable program requirements (e.g., annually for Personnel Assurance Program positions).

c. Fitness for Duty. This examination is normally limited to determining the health status of an employee who has been absent from work or who has a performance problem.

(1) The examination is performed as soon as possible on the day—

(a) the employee returns to work after being absent—

1 1 or more workdays due to a work-related illness or injury or

2 5 or more consecutive workdays due to a non-work-related illness or injury or

(b) a supervisor questions an employee's ability to perform assigned work in a satisfactory manner.

(2) The examination should focus on the reason for the absence, the effect the illness or injury will have on the employee's ability to perform the work in light of the particular exposures, and whether an accommodation is needed.

(3) The examination is not needed for employees who are returning from workers' compensation status when the medical support staff has previously reviewed the medical documentation and/or the Department of Labor's occupational health nurse approves the employee's return to the position.

d. Postincident. This is a general physical examination that is performed when a hazardous incident has occurred, even though an employee who has been exposed may not have reported any medical problem or has been absent. The purpose of the examination is to determine whether the incident has affected the employee in any way. It should be performed as soon after the incident as possible and focus on the exposure that occurred.

e. Termination. The termination examination is a general physical performed when an employee is preparing to end work in a position with a hazardous exposure(s) because of a job change, separation, or retirement. The purpose of the examination is to determine and record the employee's health status at the conclusion of such work.

2. EXAMINATIONS FOR EMPLOYEES IN NONHAZARDOUS POSITIONS.

a. Fitness for Duty. This examination may be offered on the same terms as described in paragraph 1c above. The cost should be borne by the organization when the examination is conducted because of a work-related illness or injury or when a supervisor requests the examination.

b. Postincident. This examination may be offered when a hazardous incident has occurred, even though an employee who has been exposed may not have reported any medical problem or has not been absent, but may have been accidentally involved. The purpose of the examination is to determine whether the incident has affected the employee in any way. It should be performed as soon after the incident as possible, focusing on the exposure that occurred. Depending on the circumstances of the incident, the organization may bear the cost of the examination.

c. Health Screenings. These are examinations that focus on specific body functions or diseases that may be offered periodically to all employees or a selected group of employees, such as all employees over a particular age. The purpose of the examination is to determine the health status of an employee as part of a preventive care program. For more information on health screenings, including examples and time off for an examination, see Appendix C. The cost may be borne by the organization or the employee, or the cost may be shared.

d. Termination. This is a general physical examination performed when an employee is preparing to separate or retire. The termination examination may be offered when an employee has been exposed to a hazardous condition during his/her employment. The cost should be borne by the organization when an employee previously received a postincident examination; otherwise, the cost may be borne either by the organization or the employee, or the cost may be shared.

3. EMERGENCY FIRST AID. All employees should be treated to alleviate pain, discomfort, and anxiety without undue delay.

a. Work-Related Illness or Injury. If an illness or injury cannot be fully treated by the medical support staff, the employee should be promptly referred to an appropriate medical facility or the employee's attending physician.

(1) As long as the employee is alert and capable of making a choice, the employee has the right to choose where treatment will be provided.

(2) Appropriate workers' compensation claim forms should be available and provided to the employee when the employee is sufficiently able to deal with the claims process (see the DOE Workers' Compensation Handbook).

b. Non-Work-Related Illness or Injury. Other than emergency first aid, treatment is discretionary and based on resources available.

CHAPTER VI. PROGRAM ADMINISTRATION

This chapter offers guidance on operating an occupational medical program. It is not intended to mandate staffing levels but to address the resources, internal control techniques, and educational activities that should be considered. Appendix B, "Lessons Learned," describes lessons learned about managing and/or operating successful occupational medical programs.

1. STAFFING. The staffing of an occupational medical clinic/unit, whether onsite or available offsite under a contract or inter-Agency agreement, depends on several factors:

   a. the size of the employee population serviced;

   b. the geographical distribution and location of employees and the degree of isolation from the community and other needed medical services;

   c. the age and gender distribution of the employees serviced;

   d. the shifts worked;

   e. the turnover rate of both the serviced employees and the medical support staff;

   f. the extent of occupational hazards and associated medical surveillance requirements;

   g. the types and complexities of the job tasks and operations performed by the serviced employees;

   h. the types of services/activities/programs required, including the annual number and types of examinations; and

   i. the types of services/activities/programs desired, including those negotiated in labor agreements.

   For locations with fewer than 100 employees, services should be provided under contract with a local provider (such as a clinic, private physician, or hospital) or by another Agency or contractor; however, at least one employee per shift should be trained and currently qualified in first aid and CPR.

2. FACILITIES.

   a. General. When determining whether a health facility should be provided onsite or an existing onsite facility eliminated, the following factors should be considered:

      (1) the amount of time an employee will be away from his/her job obtaining medical treatment or services in the absence of an onsite facility;

(2) how quickly medical response is needed if an accident or incident occurs;

(3) the proximity of the nearest health facility;

(4) the size of the employee population serviced;

(5) the anticipated workload for an onsite facility, by type of work;

(6) the anticipated staffing for an onsite facility; and

(7) the cost to establish and maintain the facility, including construction and equipment costs.

b. Layout. The following guidelines apply.

(1) The facility should be located in an area readily accessible to employees and to transportation. Accessibility is a key factor in employees using medical services and is very important to the overall effectiveness of the program.

(2) The facility should be spacious, well lighted, and well ventilated and have appropriate climate control.

(3) The facility should have waiting, consultation, examining, and emergency treatment areas and toilets and may have a laboratory, radiology room, rest or recovery rooms, dressing rooms, and shower or tub facilities adequate to ensure privacy and comfort.

(4) The facility should have space for records storage.

3. EQUIPMENT.

a. General. The site occupational medical director or senior medical staff should ensure medical equipment is—

(1) adequate in terms of present-day accepted standards of medical practice,

(2) maintained in good working order, and

(3) properly calibrated.

Equipment should be selected based on the specific needs of the work site. Preference should be given to devices that can provide direct input to computerized data systems.

b. The following is a list of the equipment typically found in a DOE medical facility.

(1) Equipment for monitoring, handling, and decontaminating radioactively contaminated or chemically contaminated casualties.

(2) Audiometer with a testing booth that meets Office of Safety and Health Administration standards.

(3) Cardiac defibrillation and related monitoring equipment adequate for portable use.

(4) Electrocardiograph equipment.

(5) Emergency power supply.

(6) Physiotherapy equipment.

(7) Pulmonary function and pulmonary resuscitation equipment.

(8) Radiological equipment.

(9) Standard color vision plates (Ishihara, Dvorine, or American Optical).

(10) Standard distant and near vision acuity eye charts or optical testers.

(11) Suction equipment.

4. FINANCIAL CONSIDERATIONS.

a. Budget. The annual budget process should consider the following:

(1) assessment of needs that addresses the priorities listed in Chapter I of this Guide;

(2) review of existing "wait" lists (e.g., a list of equipment purchases, activities, or programs that have been put on hold pending available resources);

(3) review of historical data and statistics such as the current and previous year's annual management reports;

(4) update of pricing information on desired equipment or services (FOH will provide estimates that can be compared with the information provided by vendors and other Agencies; DOE contractors in the area also can provide comparative information);

(5) review of administrative overhead charges by vendors and, if used, FOH;

(6) estimation of travel costs, which at a minimum should be calculated for medical staff visits to sites/employee travel to the medical staff for services, when facilities or personnel are geographically dispersed, and attendance at conferences; and

(7) assessment of education and training needs (see paragraph 5 on education and training).

b. Cost Analysis/Containment. The following cost reduction measures should be considered periodically, particularly during preparation of annual budgets or when a contract is being considered or is about to end.

(1) Compare in-house services with services under contract.

(2) Obtain three estimates for each service.

(3) Search for free services or activities such as educational seminars offered by health organizations, local hospitals, or speakers bureaus sponsored by professional groups.

(4) Check current and back issues of *Business and Health* magazine, which normally has a section on cost-benefit analyses.

(5) Evaluate and communicate the risk versus the benefits of activities, services, and programs.

(6) Track costs by activity, service, and/or program and compare the costs to the number of employees that use each to obtain the cost per employee. Reevaluate nonessential activities, services, and/or programs with high costs per employee.

(7) Have program offices (customers) cover or share costs.

(8) Check "hidden" costs (i.e., charges that are not very apparent in bills and/or inappropriate charges) and identify targets for cost-benefit comparisons. Examples of such costs/targets may include the following:

(a) the costs to interpret medical tests such as electrocardiographs,

(b) phlebotomy charges,

(c) pickup and delivery charges,

(d) report preparation charges,

(e) document copying charges,

(f) urinalysis,

(g) costs generated by improper calibration of equipment, and

(h) costs for specific laboratory tests such as chemistry profiles.

Note that costs can vary significantly for a variety of reasons, including remote locations and supply and demand.

5. EDUCATION AND TRAINING.

a. State Requirements. Most states require continuing education credits to satisfy state professional licensing, registration, and certification requirements. Some of these credits can be obtained by attending DOE conferences and regular meetings of local professional groups or by completing correspondence courses. Although the number of credits required may vary among states, the following are typical.

(1) Physicians: 100 credits every 2 years.

(2) Nurses and nurse practitioners: 75 credits every 5 years.

b. Types of Training. Training programs in the following areas should be considered when determining the training needs of the medical staff. They are offered through a variety of sources.

(1) Certifications.

(a) Occupational medicine for physicians.

(b) Medical review officer to review drug testing results.

(c) Occupational health nurse or nurse practitioner.

(d) Geriatrics.

(e) Medical technician.

(2) Case management.

(3) CPR.

(4) Use of specific equipment, including computers and software packages.

6. INTERNAL CONTROLS. The following internal controls and documents should be considered to ensure the program is administered efficiently.

a. Standard operating procedures book, which should contain—

(1) standing orders (i.e., the physician's orders for a nurse), signed by the physician and nurse, which authorize the nurse to administer certain medications in particular situations or to provide routine services such as allergy shots;

(2) applicable Orders, this Guide, local implementing memorandums, and OPM/GOVT-10, which is the Privacy Act system notice regarding Employee Medical File System Records;

(3) the local emergency response plan (see DOE G 151.1-1, *Emergency Management Guide,* Volume IV, Part 3, Emergency Medical Support, dated 8-21-97);

(4) the medical surveillance plan, if applicable;

(5) local organization charts;

(6) instructions on how to operate the telephone system and key telephone numbers, if the provider is outside DOE;

(7) names of service providers (e.g., testing laboratories, equipment calibrators,) and pertinent telephone numbers;

(8) components of exams, including who gets them and when;

(9) blood-borne pathogens policy;

(10) equipment log or inventory; and

(11) pertinent forms (see Appendix D).

b. Database management, particularly a suspense system.

c. Monthly peer reviews of employee charts.

d. Files with copies of each medical staff member's qualifications, licenses, registrations and/or certifications.

e. Training files on all medical support staff employees.

f. Documentation on the location of staff position descriptions and performance standards if copies are not in the procedures book.

g. Copy of the pertinent State nurse practice act.

h. Files with copies of local plans that affect the medical support staff (e.g., plans for exposures and emergency response).

i. Office of Workers' Compensation Program claims forms, processing procedures, and the local workers' compensation program coordinator's phone number.

CHAPTER VII. SERVICE PROVIDERS

This chapter describes ways of providing occupational medical services and factors to consider when determining how these services should be provided at different locations.

1. IN-HOUSE.

The extent of services, activities, and/or programs may vary significantly among sites, depending on site needs, geographical separation from community resources, and staff skills available onsite. Normally, the services of onsite facilities—whether staffed with Federal employees, DOE contractors, or other contractor staff—will be supplemented with offsite services when the services can be provided at lower cost by outside vendors or when more expertise is needed. (Chapter VI of this Guide discusses various resource considerations.)

2. INTER-AGENCY AGREEMENTS.

This alternative should be pursued when a DOE element is located near another Federal agency and

a. the DOE element cannot afford in-house services,

b. the other Agency has an existing facility that meets the guidelines in this Guide, and/or

c. services can be provided more cheaply than with an in-house or non-Government provider.

The most common provider in this category is FOH. FOH agreements may be customized as needed. The language in FOH agreements may be adopted or modified, as needed, for any inter-Agency agreement or used as a statement of work when seeking an outside provider. [DOE has a Memorandum of Understanding with the Department of State (DOS) which allows DOE to participate in the DOS medical program at locations overseas.]

3. SUPPORT SERVICE CONTRACTS.

Support service contracts include those with DOE contractors and those with private vendors for specific services. When using a DOE contractor, a statement of work and specific task assignment is prepared and submitted to the local procurement office. If a master contract exists that involves an indefinite delivery (i.e., an open, purchase-as-needed provision), a purchase request should be prepared, accompanied by a statement of work. If an outside vendor is being sought, a purchase request, accompanied

by a very specific statement of work, is sent to the local procurement office. The following is a list of possible outside vendors.

a. American Cancer Society, American Heart Association, Heart and Lung Association, Kidney Foundation, etc.

b. Community hospitals.

c. "Fee-for-service" providers, such as staff to run a fitness facility.

d. Independent health care providers, including a local occupational medical clinic or a private physician or nurse.

e. Laboratory service providers (e.g., for blood or substance abuse testing).

f. Radiological service providers.

g. University medical staff.

h. Wellness program companies.

i. YMCA or YWCA.

The first place to look for an appropriate provider is the telephone directory in the area where the service is needed. DOE consultants are also available through the Oak Ridge Institute of Science and Education, local professional groups, and speakers bureaus.

CHAPTER VIII. EVALUATIONS/ASSESSMENTS

This chapter describes roles of the organizations involved and the evaluation process and criteria.

1. ROLES.

   a. Office of Human Resources Policy and Planning is responsible for ensuring that DOE Federal occupational medical programs are evaluated and for following up on issues identified as a result of self-evaluations or formal evaluations.

   b. Office of Office of Independent Oversight and Performance Assurance is responsible for providing technical assistance and conducting or coordinating formal program evaluations (medical expertise and funding are available in or through that organization).

   c. DOE elements with delegated personnel authority are required to conduct self-evaluations at least annually (see DOE O 341.1, paragraph 5c). Technical assistance for conducting self-evaluations will be provided by staff from the Office of Independent Oversight and Performance Assurance and the Office of Human Resources Policy and Planning.

2. PROCESS.

   a. Self-Evaluations are based on DOE Human Capital Management Improvement Program metrics that indicate how well the program is accomplishing its mission.

   b. Technical Assistance Visits and Evaluations.

      (1) An onsite evaluation or technical assistance visit may be scheduled when one of the following events occurs:

         (a) significant issues, as determined by either the DOE element or the Office of Human Resources Policy and Planning, which reviews all self-evaluation reports, arises as a result of self-evaluations;

         (b) a third party raises significant issues that warrant further investigation; or

         (c) the DOE element requests an evaluation or visit.

      (2) The DOE element may be asked to respond to a request for additional information before it is determined that an onsite evaluation is needed or in preparation for an evaluation.

(3) Technical assistance visits may be provided or evaluations may be conducted by one person or by a team, depending on the scope of the evaluation and occupational medical program. In either case, the evaluators may include staff from the Office of Independent Oversight and Performance Assurance; qualified employees from other Departmental elements, DOE contractor organizations, or approved DOE consultants; or a combination of any of these individuals.

(a) While onsite, the evaluator or team normally holds an opening session with the medical support staff and appropriate managers; reviews records and programs, including medical records and program documentation; reviews the status of the last corrective action plan; interviews managers, medical staff, a sampling of employees, and union representatives, if applicable; and holds a closeout session with the medical support staff and appropriate managers to discuss the draft report.

(b) Every effort is made to reach agreement on the draft report while the evaluators are onsite.

(4) The final report is issued jointly by the Director of Human Resources Management and Office of Independent Oversight and Performance Assurance within 30 days after agreement is reached by the managers responsible for issuing and implementing the draft.

(a) Organizations have 30 days to comment on the final report and submit a corrective action plan, if necessary, to address findings.

(b) Upon receipt of the corrective action plan, staffs of the Director of Human Resources Management and Office of Independent Oversight and Performance Assurance will jointly resolve any differences in opinion regarding it.

3. EVALUATION CRITERIA. Organizations are evaluated using the following criteria.

a. The requirements in applicable DOE Orders, Notices, and Manuals and the Code of Federal Regulations and applicable requirements issued by other Agencies such as the Occupational Safety and Health Administration.

b. The guidelines contained in this Guide. Deviation is acceptable when there are sound reasons for it.

c. The focus of an evaluation is determined by current management issues, program priorities, and the most recent report and corrective action plan.

CHAPTER IX. MEDICAL INFORMATION AND RECORD KEEPING

This chapter describes the ownership of records, access to records, types of information that may be collected, confidentiality, and storage and maintenance of records. This information should be included in any service agreement or contract. The following is an acceptable approach to fulfilling the record-keeping requirement in DOE O 341.1, paragraph 4a(1).

1. OWNERSHIP.

   DOE or OPM owns all medical records on DOE Federal employees no matter where they are located or how they may be maintained (hard copy, microform, or automated form). Department of Labor owns and maintains the official workers' compensation claim records.

2. ACCESS.

   a. The following have access to an employee's medical information as indicated.

      (1) the organizations and individuals indicated in OPM/GOVT-10, Employee Medical File System Records (see 57 Federal Register 35699, 8/10/92), which establishes the Federal medical records system and describes the routine uses of the records;

      (2) the employee or his/her representative;

      (3) union officials have access to statistical exposure records and, when designated as representatives in writing by employees, individual medical files, unless the provision in 5 CFR Section 297.205 applies; and

      (4) supervisors; occupational medical program administrators and evaluators; and medical support, industrial hygiene, human resources, payroll, and legal staffs, on a need-to-know basis.

   b. Supervisors are entitled to know the following information—

      (1) whether or not an employee is able to perform his/her job;

      (2) how long the employee will not be able to perform all or part of his/her normal duties;

      (3) what accommodation, if any, is needed to perform them; and

      (4) when the employee needs to be absent for personal treatment and/or recuperation or care for a family member under the Family and Medical Leave Act.

c. Medical support staff may request and review in-depth medical information, including diagnoses, operative procedures, and any medications that may pertain to an employee's medical condition to determine the employee's fitness for duty.

d. Other officials may review individual medical files or personal information when the information is needed to ensure that sufficient documentation exists to support an absence or to fulfill requirements of their programs, such as to evaluate environmental conditions, to implement an occupational medical program, or to place an employee in another position based on the employee's ability to perform.

3. MEDICAL CERTIFICATE. Appendix E is a sample medical certificate that reflects the type of information that may be used to inform pertinent officials of an employee's or employee's family member's medical status and/or to document an employee's absence. (Note: Documentation is described in 5 CFR, Sections 630.403 and 630.1207; DOE O 322.1A, *Pay and Leave Administration and Hours of Duty,* dated 5-8-98, paragraph 4b(8); and the DOE *Handbook on Leave and Absence* on page 3 and extensively at Appendix F3 beginning on page 59).

a. An employee may give the form with attachments to the pertinent attending health care provider.

(1) When the attending health care provider completes the form without Attachment 1, it may be reviewed by the supervisor.

(a) The supervisor may ask the medical support staff to review and comment on the information when the supervisor is not comfortable with the information.

(b) If, in the opinion of the medical support staff, additional information is needed to determine the employee's or family member's condition, the medical support staff should specify the information needed on Attachment 1 and send it to the attending health care provider to be completed and returned to that staff.

(2) If Attachment 1 has been completed with detailed medical information, then the document should be sent directly to the medical support staff and the information from Part II provided the supervisor.

b. The medical certificate may also be completed by the medical support staff at an employee's or supervisor's request when the medical support staff has previously examined or will exam the employee.

4. CONFIDENTIALITY. Because medical information is regarded as sensitive, personal information, care is needed to ensure that medical information is released only to those who should have access to it in accordance with Public Law 104-191, Health Insurance Portability and Accountability Act (HIPAA); 5 CFR 293.504(b), 293.505(c); 45 CFR

Parts 160 through 164; DOE O 471.2, Identifying and Protecting Official Use Only Information; and OPM/GOVT-10.

5. STORAGE, PROTECTION, AND MAINTENANCE. Medical records should be maintained, protected, and controlled in accordance with 5 CFR 293.505, OPM/GOVT-10, and the following medical record keeping practices to ensure quality.

   a. Problem-oriented records should be identified and resolved as quickly as possible.

   b. The weed records system should be used when appropriate.

   c. Subjective, objective, assessment, and plan notes kept in medical records are subject to being released to the respective employees under the Privacy Act.

   d. X rays should be copied to microform.

6. QUALITY. Employee medical records should accurately describe all health unit services employees receive while employed by DOE and include applicable exposure information.

APPENDIX A. FEDERAL OCCUPATIONAL HEALTH (FOH) CONTACT

For information on clinical services available from FOH, contact the following.

Lillian C. Koenig
Associate Vice President Program Development, Clinical Services
Telephone: (301) 594-0248
Fax: (301) 594-4991
E-mail: LKoenig@email.foh.dhhs.gov
Web site: http://www.foh.dhhs.gov

APPENDIX B. LESSONS LEARNED

This appendix shares lessons learned about managing/operating a successful medical program.

1. Record all information collected.

2. Prepare monthly and annual summaries of activities and numbers of employees serviced for management. This information may help justify changes in staffing levels and additional equipment. It also serves to keep managers informed on a program that is otherwise not visible.

3. Track significant events such as screenings or medical surveillance evaluations for trend analysis.

4. Get top managers involved. Without that level of support, services, activities, and/or programs will not materialize.

5. Promote programs and program staff.

6. Encourage customer comments and/or inputs.

7. Anticipate hidden costs. [See Chapter VI, paragraph 4b(8) of this Guide.]

APPENDIX C. PREVENTIVE HEALTH SCREENINGS

The following documents address the need for, and Federal employees' participation in, preventive health screenings.

1. Attachment 1 is President Clinton's memorandum, Preventive Health Services at the Federal Workplace, dated January 4, 2001, that authorizes Departments and Agencies to permit up to 4 hours of excused absence (administrative leave) for employees with fewer than 80 hours of accrued sick leave to participate in preventive health screenings.

2. Attachment 2 is Secretary Abraham's memorandum, Employee Work Life Programs, dated April 25, 2001, that expands the use of the 4 hours of excused absence for preventive health screenings to all DOE employees.

3. Attachment 3 is an implementing memorandum from the Director of Human Resources Management on Preventive Health Screenings, dated May 18, 2001, that provides examples of appropriate screenings and describes how to report the absence.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release **January 4, 2001**

January 4, 2001

MEMORANDUM FOR THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

SUBJECT: Preventive Health Services at the Federal Workplace

Today, as we celebrate the enactment of the Breast and Cervical Cancer Prevention and Treatment Act that I signed into law in October of last year, I am heartened by the progress being made in expanding access to preventive care for cancer and other serious diseases. We know a great deal about screening procedures that can detect diseases early, and about behaviors, such as smoking cessation and sun avoidance, that can greatly reduce a person's risk of disease. The challenge that remains is to ensure that all Americans not only take advantage of the screening programs and other effective preventive measures that are available and appropriate, but that they make positive changes in their lifestyles before disease develops.

The workplace is a logical place to provide employees with health information and services to help them learn about preventive health. The Federal Government, the Nation's largest employer, has already developed many programs to encourage preventive health care for its employees. These measures, available to Federal employees through the Federal Employee Health Benefits Program, cover a broad range of preventive health services, including screening for prostate, cervical, colorectal, and breast cancer, and screening for sickle cell anemia, blood lead level, and blood cholesterol level. The programs also provide for all recommended childhood immunizations, well child care, and adult preventive care visits. In addition, the Federal personnel system provides employees with considerable flexibility in scheduling their hours of work and taking time off for medical needs, including routine examinations and preventive screenings. Many agencies offer creative, effective employee health programs that provide opportunities for employees to take advantage of preventive health screenings at the worksite.

There is still room for progress. Therefore, I am today directing Federal departments and agencies to review their policies and make maximum use of existing work schedule and leave flexibilities to allow Federal employees to take advantage of screening programs and other effective preventive health measures. Each department and agency should also inform its employees of the various work schedule and leave flexibilities available to them to participate in these preventive screenings and examinations. Such flexibilities include promoting alternative work schedules (flexible and compressed work schedules), which allow for a variety of working arrangements tailored to fit the needs of individual employees, granting leave under the Federal Government's sick and annual leave programs, and granting excused absence to employees to participate in agency-sponsored preventive health activities. In the case of employees with fewer than 80 hours (two weeks) of accrued sick leave, I am directing each department and agency to establish a policy that provides up to 4 hours of excused absence each year, without loss of pay or charge to leave, for participation in preventive health screenings.

I am also directing agencies to develop or expand programs offered at the worksite to help employees understand their risks for disease, obtain preventive health services, and make healthy lifestyle choices, and to share these initiatives with the Office of Personnel Management (OPM) within 120 days. The OPM will use this information to identify agency best practices. Finally, I direct the OPM to prepare guidance to assist agencies in carrying out this directive. Agencies will carry out this policy within available appropriations, and to the extent permitted by law and consistent with the Administration's budget priorities.

I want the Federal Government to serve as a model for the rest of the country. While Federal agencies

have led the way in many instances, I want to go even further in demonstrating that preventive health care for all employees is not only desirable, but also very practical and sensible.

WILLIAM J. CLINTON

The Secretary of Energy
Washington, DC 20585

April 25, 2001

MEMORANDUM FOR DEPARTMENT OF ENERGY EMPLOYEES

FROM : SPENCER ABRAHAM

SUBJECT: EMPLOYEE WORK LIFE PROGRAMS

As I have learned more about the Department's activities, I have been especially impressed by the Department's work life programs. Many of these programs are designed to help us balance our responsibilities at the Department with our responsibilities at home--and I support them, because they help us realize the value of the human resources that are so crucial to the accomplishment of DOE's mission.

I would like to support two employee work life programs at this time:

DOE-FLEX: Known as telecommuting or Flexiplace, DOE-FLEX can help us save on energy consumption, commuting costs, time, and wear and tear on ourselves and our automobiles. Further, by focusing on energy conservation, this program is responsive to our Agency mission. I was pleased to see that Congress shares this view--the Transportation Appropriations Act for FY 2000 now mandates government-wide telecommuting policy. I fully support the existing DOE-FLEX policy and I encourage all DOE managers and supervisors to support DOE-FLEX by working to identify and remove barriers to employees' working at their homes or at other approved telecommuting locations.

Preventive Health Measures: It is important to maintain good personal health in order to maintain the health of the Agency. In this regard, I want the Department of Energy to establish and maintain leadership in employee preventive health care. Accordingly, I am directing that all Department of Energy employees are to be granted up to 4 hours of excused absence each leave year in order to participate in preventive health screenings. The Office of Management and Administration will issue guidelines in support of this new policy in the near future.

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I am pleased that there are so many programs at DOE designed to improve the quality of work life such as family friendly leave, transit subsidies, child care subsidies, wellness programs, and Employee Assistance Programs. Through these and other programs, we can demonstrate our commitment to the employees of our Department and their families.

Department of Energy
Washington, DC 20585

May 18, 2001

MEMORANDUM FOR HEADS OF DEPARTMENTAL ELEMENTS

FROM: TIMOTHY M. DIRKS
DIRECTOR OF HUMAN
RESOURCES MANAGEMENT

SUBJECT: PREVENTIVE HEALTH SCREENINGS

As you know, the Secretary recently issued a statement on Work/Life Programs, specifically addressing the issues of telecommuting and preventive health measures; a copy of the statement, which was distributed via DOECAST, is attached to this memorandum. The statement provided that the Office of Management and Administration would issue guidelines in support of the new Secretarial policy which authorizes all Department of Energy Federal employees "up to 4 hours of excused absence each leave year in order to participate in preventive health screenings." The following responds to the Secretary's direction for guidelines and provides related information.

Application of health screening policy:

(1) Examples of preventive health screenings include, but are not limited to, screening for prostate, cervical, colorectal, and breast cancer, sickle cell anemia, blood lead level, and blood cholesterol level. Other examples include screening for immune system disorders, such as HIV, and blood sugar level testing for diabetes. Questions regarding the scope of the term "preventive health screening" as it relates to an individual medical test can be referred to the local medical support staff.

(2) Absence from the work site due to health screenings should be recorded as "excused absence," formerly termed "administrative leave," time and attendance code "060." The U.S. Office of Personnel Management (OPM) has advised us that absences due to preventive health screenings are not expected to be tracked; accordingly, no new time and attendance code has been established. When Standard Form 71 or its analog is used for leave requests, the reason for the absence should be recorded in the appropriate comment space. Requests for absence for preventive health screenings are subject to prior approval similar to requests for annual leave or sick leave for medical appointments. The period of time in which the 4 hours' excused absence may be used is one ~~calendar~~ leave year; unused leave may not be accumulated from one ~~calendar~~ leave year to the next. Employee visits to the health unit for on-site preventive health screenings, or participation in health fairs, should be treated according to local practice.

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Other health-related activities:

As managers of DOE programs, you have a substantial role in promoting employee participation. Your responsibilities in this area will be further described in the DOE directive on leave and the directive on employee health services. Both directives will be modified shortly to reference your authority to grant excused absence for preventive health screenings. In the meantime; however, you may grant excused absence for this purpose consistent with guidance in the above paragraph.

The Office of Human Resources Management will soon be issuing guidance templates on the new DOE excused absence policy that can be adapted for distribution and use by local human resources servicing offices. In establishing site-specific programs, management at affected locations should fulfill any associated collective bargaining obligations.

Questions about the administration of local leave policy or practice, including negotiated agreements, may be directed to your local human resources servicing offices. Questions on Departmental health services and Federal leave policy may be directed to Bruce Murray, (202) 586- 3372, in the Human Resources Policy and Programs Division; Bruce is also available via electronic mail on **bruce.murray@hq.doe.gov**.

Attachment

cc: Human Resource Directors
Presidents of the DOE Federal Unions

APPENDIX D. FORMS

The following forms are essential to the operation of an occupational medical unit.

- Certificate of Medical Exam (for Federal employees only)—

  – SF-88, Medical Record—Report of Medical Examination, dated 10-94.

- Forms for recording—

  –allergy shots,
  –consent, including flu vaccine consent
  –demographics,
  –electrocardiograph results,
  –laboratory reports,
  –medical history,
  –occupational work history,
  –physical examinations,
  –progress notes, and
  –respirator clearance.

- Equipment forms for recording equipment inventory, calibration, and repairs.

- Medical records release.

- Occupational Safety and Health Administration 300 log and DOE Computerized Accident/Incident Reporting System (CAIRS).

- Problem list—for an employee's medical file.

- Workers' compensation [i.e., the U.S. Department of Labor Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation (Form CA-1), dated 4-99].

APPENDIX E. SAMPLE MEDICAL CERTIFICATE

Instructions: The information on this form is to be provided by the employee and the pertinent patient's health care provider**.** Please review the form before completing all applicable blanks with either a check mark or appropriate information. Attachment 1 must be returned to the medical support staff in a sealed envelope.

PART I: Patient Information (employee or health care provider completes)

A. Employee's name: _____

B. Family member's name: _____

Relationship to employee: _____

PART II: Information for the Employee's Supervisor (health care provider completes)

A. Regarding the employee's condition.

1. Does it qualify as a serious condition (see Attachment 2)? ☐ Yes ☐ No
(If yes, skip number 2 and complete numbers 3, 4, and section C. If no, complete numbers 2, 3, and 4.)

2 Employee is expected to be absent from work until _____ .
Date

3. Employee is able to return to duty

☐ and perform normal duties.

☐ and perform normal duties, but with the following recommended accommodations: _____

_____

_____

☐ and perform limited duties, such as: _____

_____

_____

4. Employee will need to be absent again for

☐ a followup examination(s) on [date(s) or frequency]_____

_____

☐ continuing treatment(s) on [date(s) or frequency] _____

_____

B. Regarding a family member's condition.

1. Does it warrant having the employee's care or presence to provide any of the following.

   (a) Psychological comfort and/or physical assistance? ☐ Yes ☐ No

   (b) Assistance for basic medical, hygienic, nutritional, safety, or transportation needs? ☐ Yes ☐ No

   (c) Assistance in making arrangements for such needs? ☐ Yes ☐ No

2. Does it qualify as a serious condition (see Attachment 2)? ☐ Yes ☐ No
   (If yes, skip numbers 3 and 4 and go to section C. If no, complete numbers 3 and 4.)

3. Employee is expected to be absent from work to care for this family member until _____ .
   Date

4. Employee will need to be absent to accompany the family member to

   ☐ a followup examination(s) on [date(s) or frequency]_____

   ☐ continuing treatment(s) on [date(s) or frequency] _____

C. Regarding a serious health condition.

1. The condition began _____ .
   Date

2. The condition is ☐ expected to last _____ weeks/months.

   ☐ a chronic or continuing condition with an unknown duration.

3. The patient ☐ is ☐ is not currently incapacitated.

4. Please complete Parts I and II of Attachment 1 for the employee's medical support staff.

PART III:Health Care Provider Information (health care provider completes)

A. Name: _____

B. Position/Title: _____

C. Organization: _____

D. Address: _____
_____

E. Phone No.: _____

F. Date: _____

G. Signature: _____

PART IV: Employee Information (employee completes)

A. Briefly describe the care that you expect to provide your family member:_____
_____
_____
_____

B. Authorization:

I authorize_____(my health care provider) to complete and provide the information in this medical certificate to my supervisor and, if applicable, my medical support staff, along with any additional information that may be requested by the medical support staff.

Signature: _____ Date: _____

Attachments:

1. Information for the Employee's Medical Support Staff
2. Definition and Identification of a Serious Health Condition

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Sample Medical Certificate Attachment 1

Information for the Employee's Medical Support Staff
(health care provider completes)

PART I: Patient Information

A. Employee's name: _____

B. Family member's name: _____
Relationship to employee: _____

PART II: Serious Health Condition

Provide a brief description of the incapacitation and the examination and/or treatment that will be provided by the health provider: _____
_____
_____
_____

PART III: Additional Information Needed [medical support staff will check the paragraph(s) to be completed]

A. Diagnosis: _____
_____
_____
_____
_____
_____

B. Operative procedures: _____
_____
_____
_____
_____
_____

C. Medication(s): _____
_____
_____
_____
_____

Please return this attachment in a sealed envelope.

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Sample Medical Certificate Attachment 2
Serious Health Condition
(As defined in the Family and Medical Leave Act of 1993)

A serious health condition means an illness, injury, impairment, or physical or mental condition that involves one of the following.

1. **Inpatient care** (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Continuing treatment** that includes (but is not limited to) examinations to determine whether there are serious health conditions and evaluations of such conditions if the examinations or evaluations determine that serious health conditions exist. Continuing treatment may include one or more of the following.

   a. A period of incapacity of more than 3 consecutive calendar days, including any subsequent treatment or period of incapacity relating to the same condition, that also involves—

      (1) treatment two or more times by a health care provider, by a health care provider under the direct supervision of the affected individual's health care provider, or by a provider of health care services under orders of, or on referral by, a health care provider or

      (2) 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 (e.g., a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition).

   b. Any period of incapacity due to pregnancy, or for prenatal care, even if the affected individual does not receive active treatment from a health care provider during the period of incapacity or the period of incapacity does not last more than 3 consecutive calendar days.

   c. Any period of incapacity or treatment for a chronic serious health condition that—

      (1) requires periodic visits for treatment by a health care provider or by a health care provider under the direct supervision of the affected individual's health care provider;

      (2) continues for 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 (e.g., asthma, diabetes, epilepsy). (Note: The condition is covered even if the affected individual does not receive active treatment from a health care provider during the period of incapacity or the period of incapacity does not last more than 3 consecutive calendar days).

d. A period of incapacity, permanent or long-term, because of a condition for which treatment may not be effective; the affected individual must be under the continuing supervision of, but need not be receiving active treatment from, a health care provider (e.g., Alzheimer's, severe stroke, or terminal stages of a disease).

e. 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 of more than 3 consecutive calendar days in the absence of medical intervention or treatment (e.g., chemotherapy/radiation for cancer, physical therapy for severe arthritis, dialysis for kidney disease).

A serious health condition does <u>not</u> include the following:

1. routine physicals;

2. eye or dental examinations, routine dental or orthodontia problems, or periodontal disease;

3. a regimen of continuing treatment that includes the taking of over-the-counter medications, bed-rest, exercise, and other similar activities that can be initiated without a visit to the health care provider;

4. a condition for which cosmetic treatments are administered, unless inpatient hospital care is required or unless complications develop;

5. an absence because of an employee's use of an illegal substance, unless the employee is receiving treatment for substance abuse by a health care provider or by a provider of health care services on referral by a health care provider;

6. the common cold;

7. the flu;

8. earaches;

9. upset stomach;

10. minor ulcers;

11. headaches (other than migraines);

12. allergies;*

13. restorative dental or plastic surgery after an injury;*

14. removal of cancerous growths;* or

15. mental illness resulting from stress.*

*only if such conditions do not require inpatient care or continuing treatment by a health care provider