UNIVERSITY OF LOUISVILLE.

Human Resources
1980 Arthur Street
Louisville, KY 40208-2770

Attn: Betsy Waters
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Certification of Health Care Provider For Employee's Serious Health Condition (Family & Medical Leave Act)

INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by the university, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. The university must give you at least 15 calendar days to return this form.

Employee Name: _____
First Middle Last

Home Address: _____

_____
City State Zip

Telephone: ( ) _____ ( ) _____
Home Other

Employee identification number: _____

Department you are employed in: _____

Job Title: _____

Employee's essential job functions: _____

_____

For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as

"lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name: _____

Business address: _____

_____

City State Zip

Type of practice / Medical specialty: _____

Telephone: (_____) _____Fax: (_____) _____

PART A: MEDICAL FACTS:

1. Diagnosis: _____
2. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ____No ____Yes. If so, dates of admission: _____

   _____

   Date(s) you treated the patient for condition: _____

   _____

   Date of most recent visit:_____

   Will the patient need to have treatment visits at least twice per year due to the condition? ____No ____ Yes.

   Was medication, other than over-the-counter medication, prescribed? ____No ____Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment: _____

   _____
3. Is the medical condition pregnancy? ____No ____Yes. If so, expected delivery date: _____
4. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer

these questions based upon the employee's own description of his/her job functions. Is the employee unable to perform any of his/her job functions due to the condition? ____ No____Yes

5. If yes, identify the job functions the employee is unable to perform:_____

   _____

   _____

6. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

Part B: AMOUNT OF LEAVE NEEDED

7. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ____No ____Yes.
8. Estimate the beginning and ending dates of incapacity: _____through_____
9. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ____No ____Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?

   ____No ____Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from _____ through _____
10. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?

____ No ____Yes. If so, explain: _____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____month(s).

Duration: _____ hours or _____ day(s) per episode.

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

_____

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_____ _____

Signature of Health Care Provider **Date**