UNIVERSITY OF LOUISVILLE.

Human Resources
1980 Arthur Street
Louisville, KY 40208-2770

Attn: Carol Zehnder
Phone: 502.852.2964
Fax: 502.852.5665

Certification of Health Care Provider
For Family Member's Serious Health Condition
(Family & Medical Leave Act)

For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your family member or his/her 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 to care for a covered family member with a 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: _____

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____

_____ _____

Employee Signature Date

For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name: _____

Business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____Fax :(_____) _____

PART A: MEDICAL FACTS

1. Diagnosis: _____

2. Approximate date condition commenced: _____

   Probable duration of condition: _____

   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:_____

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

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

____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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): _____

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PART B: AMOUNT OF CARE NEEDED:

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

5. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.
6. Estimate the beginning and ending dates of incapacity: _____through_____.
7. During this time, will the patient need care? ____ No ____ Yes. Explain the care needed by the patient and why such care is medically necessary: _____

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8. Will the patient require follow-up treatments, including any time for recovery? ____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: _____

   _____

   Explain the care needed by the patient, and why such care is medically necessary_____

   _____

   _____

9. Will the employee be required to provide patient care on an intermittent or reduced schedule basis, including time for recovery? ____ No ____ Yes.
   Estimate the hours the patient needs care on an intermittent basis:
   _____ hour(s) per day; _____ days per week; from _____ through _____.
   Explain the care needed by the patient, and why such care is medically necessary: _____

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   _____

   _____

10. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.
    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
    Does the patient need care during these flare-ups? ____ No ____ Yes.
    Explain the care needed by the patient during flare ups, and why such care is medically necessary:

    _____

    _____

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ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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Signature of Health Care Provider **Date**