



Human Resources
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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.

_____ No _____ Yes. If so, explain: _____

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

[illegible]

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