CERTIFICATION OF HEALTHCARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)

UF | Human Resources UNIVERSITY of FLORIDA

SECTION 1: FOR COMPLETION BY THE EMPLOYEE

Instructions to the Employee: Please complete Section 1 before giving this form to your medical provider. The Family and Medical Leave Act (FMLA) permits an employer to require that you submit timely, complete and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313.

Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee Name:	**UFID:**
Job Title:	**College/Division:**
Regular Work Schedule: ☐ Full Time ☐ Part Time	**Check is job description is attached:** ☐ No ☐ Yes
Would you like to request an ADA accommodation for any restrictions indicated Section 2? ☐ No ☐ Yes	

SECTION 2: FOR COMPLETION BY THE HEALTHCARE PROVIDER

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b).

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.

Please be sure to sign the form on the last page.

Provider Name:	
Business Address:	
Type of Practice/Medical Specialty:	
Telephone:	**Fax:**

PART A: MEDICAL FACTS

1. Description of Medical Condition:_____

Approximate date condition commenced:_____

Probable duration of condition (as of date Medical Certification is completed):_____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes If yes, dates of admission:_____

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

Does the patient's condition require treatment visits at least twice per year? ☐ No ☐ Yes

2. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, the expected delivery date: _____

3. Use any relevant information in the employee's job description as reference to answer this question. If no job description was provided, answer these questions based upon the employee's own description of his/her job functions.

Is the patient unable to perform any of their job functions due to the condition? ☐ No ☐ Yes

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

_____

PART B: AMOUNT OF LEAVE NEEDED

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

If yes, estimate the dates of the period of incapacity:_____

2. Will the patient need to attend follow-up treatment appointments? ☐ No ☑ Yes

If yes, estimate the treatment schedule (i.e., time required for each appointment and recovery):

_____

3. Will the patient need to work part-time or on a reduced work schedule? ☐ No ☐ Yes

If yes, estimate the part-time or reduced work schedule that would be appropriate for the patient:

From_____ through_____, the employee can work_____hour(s) per day_____days per week.

4. Will the patient experience flare-ups of their condition (in addition to any accounted for in a reduced work schedule), for which it would be medically necessary for them to be absent from work? ☐ No ☐ Yes

If yes, provide an estimate the duration and frequency for which the employee's absence would be required:

Every_____–_____ ☐ *day(s)* ☐ *week(s)* ☐ *month(s)* an absence of_____ – _____ ☐ *hour(s)* ☐ *day(s)* can be expected.

SECTION 3: ADDITIONAL INFORMATION

Include any further relevant information. If supplementing an item above, identify the question number with your additional answer.

Signature of Health Care Provider **Date**

Any questions concerning how to complete this form or the Family Medical Leave Act, more generally, can be addressed to your UFHR-Central Leave Team at (352) 392-2477 or central-leave@ufl.edu.

The completed form can be sent via secure fax to 352-392-5166, emailed to fmla@hr.ufl.edu, dropped off in person or mailed to 903 W University Avenue, PO Box 115007, Gainesville, FL 32611-5007

Keep a copy of this form for your personal records.