

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



**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).

<b>Employee Name:</b>	<b>UFID:</b>
<b>Job Title:</b>	<b>College/Division:</b>
<b>Regular Work Schedule:</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	<b>Check if job description is attached:</b> <input type="checkbox"/> No <input type="checkbox"/> 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.*

<b>Provider Name:</b>	
<b>Business Address:</b>	
<b>Type of Practice/Medical Specialty:</b>	
<b>Telephone:</b>	<b>Fax:</b>

## 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 _____ – _____	<input type="checkbox"/> <b>day(s)</b>	an absence of _____ – _____	<input type="checkbox"/> <b>hour(s)</b>	can be expected.
	<input type="checkbox"/> <b>week(s)</b>		<input type="checkbox"/> <b>day(s)</b>	
	<input type="checkbox"/> <b>month(s)</b>			

