

FMLA LEAVE CERTIFICATION OF HEALTH CARE PROVIDER

(Must be completed and signed by Health Care provider)

1. Name of Person requesting Leave & SSN (First Name, Middle Initial, Last Name - SSN):	2. Name of PATIENT :	2b. Relationship of Patient to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Dependent Child <input type="checkbox"/> (Age of Child)
Dept: _____ Supervisor and Phone Number: _____		
3. Circle/Check the appropriate FMLA category: a. <input type="checkbox"/> Hospital Care b. <input type="checkbox"/> Absence Plus Treatment c. <input type="checkbox"/> Pregnancy d. <input type="checkbox"/> Chronic Conditions Requiring Treatment e. <input type="checkbox"/> Permanent/Long-term Conditions Requiring Treatment f. <input type="checkbox"/> Multiple Treatments (Non-Chronic Conditions)	*4. Diagnosis/Medical Facts: (What are the medical facts that support the patient's serious health condition?)	
5a. Onset and duration of condition:	5b. Date(s) of patient's present incapacity (if different from 5a):	
↻*6. NOTE: Please indicate type of leave requested: <input type="checkbox"/> Continuous: give duration of time off work: _____ <input type="checkbox"/> Intermittent: please estimate episodic leave based upon patient's past history: Frequency of illness episodes: _____ Duration of illness episodes: _____		
7. Prescribed treatment regimen and schedule: <input type="checkbox"/> Office visits: # _____ per _____ <input type="checkbox"/> Surgery (date): _____ <input type="checkbox"/> Therapy visits: # _____ per _____ <input type="checkbox"/> Procedure (type/date): _____ <input type="checkbox"/> Prescription medication: _____ <input type="checkbox"/> Other treatments (type/dates): _____ <input type="checkbox"/> Referral to other providers (who) _____		

EMPLOYEE'S OWN SERIOUS HEALTH CONDITION:

8. Is in-patient hospitalization of the employee required? <input type="checkbox"/> No <input type="checkbox"/> Yes (give dates) _____	9. Is employee able to perform work of any kind? (If "No", skip Item 10.) <input type="checkbox"/> Yes <input type="checkbox"/> No
10a. Is employee able to perform the functions of employee's position? <input type="checkbox"/> Yes <input type="checkbox"/> No 10b. If not, please describe employee's restrictions and their duration: Restrictions (include need for reduced work schedule): _____	

FAMILY MEMBER'S SERIOUS HEALTH CONDITION:

11. Will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. After review of the employee's signed statement (see Item 14 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Estimate the period of time care is needed or the employee's presence would be beneficial to care for the patient.

14. To be completed by the Person Needing Family Leave (Please attach information if applicable)
 When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.
Signature of Faculty/Staff: _____ **Work #:** _____ **Home #:** _____ **Date:** _____

15. Type of Practice (Field of specialization, if any): Print name of Health Care Provider:	Address of Health Care Provider: Office Telephone #:
* Health Care Provider Signature:	<u>Date Signed:</u>

* Required field for consideration.