Certification of Health Care Provider for
**Employee’s Serious Health Condition**
(Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE

**INSTRUCTIONS:** Please complete Section I 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 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:** ____________________________________________    Banner ___________________________________

Employee mailing address: ___________________________________________________________________________
___________________________________________________________________________

Employee Job Title: ______________________________  Employee regular work schedule: ______________________

Supervisor name: ____________________________________________________________

Employee’s essential job functions: _____________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Check if job description is attached: ______

SECTION II: For Completion by the HEALTH CARE PROVIDER

**INSTRUCTIONS:** 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. 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). **Please be sure to sign the form on the last page.**

Provider’s name and business address: ________________________________

Type of practice / Medical specialty: ________________________________

Telephone: (________) _________________________________ Fax : (________) _________________________________
**PART A: MEDICAL FACTS**

1. 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: ____________________________________

   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: ____________________________________

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: ________________

3. 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.
   If so, identify the job functions the employee is unable to perform: ____________________________________

4. 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**

5. 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.

If so, estimate beginning and ending dates for the period of incapacity

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<th>Beginning date</th>
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6. 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 __________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? ___No ___Yes.

If yes, explain: 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

**Signature of Health Care Provider**

__________________________________     Date

**PLEASE RETURN COMPLETED FORM TO:**

Carolyn Bosley  
Leave Management Administrator  
Appalachian State University  
ASU Box 32010  
Boone, NC 28608

Phone: (828) 262-6488  
Fax: (828) 262-6489

**For Completion by The Office of Human Resources, Appalachian State University**

FML: _____ YES _____ NO

Approved by: ___________________________     Designation Letter ____/____/_____