Office of Human Resources - Appalachian State University

Type: Intermittent or Continuous (To be completed by Human Resources)

FML BEG: _____/_____/_____ FML END: _____/_____/_____ DOH: _____/_____/_____

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 _____
First Middle Last

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 :(_____) _____

Employee Name _____

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):

_____

_____

_____

Employee Name _____

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
Beginning date _____ **Ending date** _____

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 ____/____/____