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
Family Member's Serious Health Condition
(Family and Medical Leave Act)

Office of Human Resources
APPALACHIAN STATE UNIVERSITY

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS: Please complete Section I before giving this form to your family member or his/her 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____Banner: _____
First Middle Last

Mailing Address: _____

Supervisor Name: _____

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____/_____/_____

Describe care you will provide to your family member and ***estimate leave dates*** needed to provide care:

_____

_____

_____

_____

_____

Employee signature: _____ Date: _____/_____/_____

Employee Name: _____ **Family Member:** _____

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. ***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: _____

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: _____

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
____ No ____Yes.
If yes, 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. 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: _____ **Family Member:** _____

PART B: AMOUNT OF LEAVE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportion needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition including any time for treatment and recovery? ___No ___Yes.

Estimate the beginning and ending dates for the period of incapacity: ____/____/____ ____/____/____

During this time will the patient need care? ___No ___Yes.

Explain the care needed by the patient and why such care is medically necessary:

_____

_____

_____

5. Will the patient require follow-up treatments, including any time for recovery? ___No __Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recover period:

_____

Explain the care needed by the patient during treatment schedule and why such care is medically necessary:

_____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___No ___ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:
_____hour(s) per day; _____ days per week from ____/____/____ through ____/____/____

Explain the care needed by the patient on this intermittent basis and why such care is medically necessary:

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from performing normal daily activities? ____No ____Yes.

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

Does the patient need care during these flare-ups? _____No _____Yes

_____ _____

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 Appalachian State University Human Resource

FML _____YES _____ NO

Approved by: _____ Designation Letter ____/____/____