

Certification of Health Care 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 II 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).

Your name: _____ Banner ID _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Department: _____ Email Address: _____

Employment Status: _____ Permanent Full-Time _____ Permanent Part-Time _____ Temporary

How long have you been employed? _____

Reason for requesting Family/Medical Leave _____

Date Leave is to begin: _____ Date Leave is expected to end: _____

Employee Signature: _____ Date: _____

SECTION 2: For Completion by the SUPERVISOR

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertification, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Supervisor name (Print) _____ Email _____

Supervisor Signature _____ Phone _____

SECTION 3: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: 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. 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, beginning date of disability and probable ending date.(Note: If condition is related to **pregnancy or for pre or postnatal care**, please enter only the period of medical disability requiring that the person be out of work).

Start 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 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 so, 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

SECTION 4: For Completion by the Human Resources Office

Family/Medical Leave is applicable in this case: ___YES ___ NO

Approved by: _____

PLEASE RETURN COMPLETED FORM TO:

**Carolyn Bosley
Appalachian State University
Human Resources
ASU Box 32010
Boone, NC 28608**

Phone: (828) 262-6488

Fax: (828) 262-6489