Pennsylvania's STATE SYSTEM of Higher Education

Family and Medical Leave Act
Family Member Serious Health Condition Certification

SECTION 1: TO BE COMPLETED BY EMPLOYEE

INSTRUCTIONS to the EMPLOYEE:

- **COMPLETE SECTION 1 BEFORE GIVING THIS FORM TO YOUR FAMILY MEMBER'S HEALTH CARE PROVIDER.** The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for an absence that may qualify as FMLA leave (Family Care Leave Without Pay) to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA protections and Family Care Leave Without Pay. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA and Family care Leave Without Pay request.
- **SECTION 2 OF THIS FORM MUST BE COMPLETED BY THE TREATING HEALTH CARE PROVIDER;** it is inappropriate for you or the family member to complete section 2. Note: If this is a request for leave for yourself or a serious injury or illness for a covered service member, you cannot use this form.
- Please obtain either: *Employee Serious Health Condition Certification* OR *Serious Injury or Illness of a Servicemember Certification* from your Human Resource Office.

Employee Name	Personnel Number

University	Work Location

Family Member / Patient Name	Relationship to Employee	If Son/Daughter, Date of Birth

Describe the care you will provide to your family member and estimate the amount of leave needed to provide this care; include a schedule, if possible for intermittent absences.

SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER:

INSTRUCTIONS: The above employee 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 on 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 response to the condition for which the employee is seeking leave. **Please sign the last page.**

When answering **Amount of Care Needed** questions, **keep in mind the patient's need for care by the employee seeking leave,** which may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. None of the questions on this form require genetic information.

Supporting Medical Certification:

1. Approximate date condition commenced	2. Probable duration of condition (be as specific as you can)
3. Approximate date **incapacity*** commenced	4. Date(s) you treated patient for condition

5. Was patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes If yes, please list most recent date of admission _____ and discharge _____

6. Will the patient need to have treatment visits at least twice per year due to the condition?

☐ No ☐ Yes

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

☐ No ☐ Yes

8. Was the patient referred to another health care provider(s) for evaluation or treatment (example: physical therapist)?

☐ No ☐ Yes If yes, state the nature of such treatments and expected duration of treatment.

*Incapacity is the inability to work, attend school or perform other regular daily activities.

9. Is the medical condition pregnancy?

☐ No ☐ Yes If yes, expected delivery date is _____.

Medical Facts:

10. Describe 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).

Amount of Care Needed (see instructions on page 1)

11. **Full-time Absence -** Was or will patient be incapacitated for a single continuous period of time due to the medical condition, including any time for treatment and recovery?

☐ No ☐ Yes If yes, specify the **begin date** _____ and **end date** _____ of the period of incapacity.

During this time, will the patient need care?

☐ No ☐ Yes

12. **Absences for Appointments -** Did or will patient need to attend follow-up treatment appointments because of the medical condition?

☐ No ☐ Yes If yes, estimate the appointment schedule, if any. Include the dates of scheduled appointments and the time required for each appointment, including any recovery period.

_____

Can appointments be scheduled during non-work hours?

☐ No ☐ Yes

13. **Absences for Flare-Ups (not part-time absences).** Will condition cause episodic flare-ups periodically preventing patient from participating in 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 patient may have over the next 6 months. (**Example:** 1 episode every three months lasting 1-2 days in duration).

Frequency: Number of times _____ per week; or Number of times _____ per month

Duration: Number of hours _____ per episode; or Number of days _____ per episode

Does the patient need care during these flare-ups?

☐ No ☐ Yes

14. **Part-Time Absences (not flare-ups).** Did or will patient require care on an intermittent or reduced time schedule basis including any time for recovery?

☐ No ☐ Yes If yes, estimate the hours the patient needs care on a part-time basis, if any.

Employee is needed to care for patient: _____ Hours per day AND _____ Days per week from

begin date _____ to end date _____

15. Explain the care that the employee will provide for the patient during any of the above noted absences and why such care is medically necessary.

By providing my signature, the undersigned health care provider certifies that the information is true and accurate.

Printed Name of Health Care Provider	Type of Practice/Medical Specialty	License Number
Address		Telephone Number
Name and Title of Staff Member (if form not completed by the Health Care Provider)		Fax Number
Signature of Health Care Provider		Date

Please return this form to the employee or to: Anna Shively, Assistant Director of Human Resources
Office of Human Resources, G-8 Sutton Hall,
1011 South Drive, Indiana, PA 15705

Phone: 724.357.2431 **Fax: 724.357.2685** **Email: ashively@iup.edu**