

Family and Medical Leave Act Employee Serious Health Condition Certification

SECTION 1: TO BE COMPLETED BY EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Complete Section 1 and then provide this form to your health care provider. Section 2 must be completed by the treating health care provider; it is inappropriate for you to complete section 2.

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 due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **You have 15 days to return this form.**

If this is a request for leave to care for a family member or next of kin, do not use this form; obtain the correct form from your human resources office.

Employee Name	Personnel Number
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University	Work Location
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Is this condition the result of a work-related injury? No Yes

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.**

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 (Example: 3 months, 1 year, etc.)
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3. Approximate date incapacity* commenced	4. Date(s) you treated patient for condition
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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:

9. Is the medical condition pregnancy? No Yes If yes, expected delivery date is _____.

10. Using the attached job description or essential functions as a guide, is patient able to perform all of his/her job functions?
 No Yes

If no, list the functions that **cannot** be performed due to this condition (do not list accommodations only list functions which cannot be performed):

Medical Facts:

11. 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

12. **Absences for Appointments** - Did or will employee need to attend medical treatments/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. **Continuous Full-time Absence** - Did or will employee 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.

14. **Non-continuous Absences** (Dates in this section cannot overlap with section 13. above)

a. Part-time Basis (set, recurring schedule)

Did or will employee need to work on a PART-TIME basis due to the medical condition? No Yes

If yes, specify the **begin date** _____ AND **end date** _____ of the part-time basis.

Estimate the hours the employee can work on a part-time basis (complete both):

Hours per day: _____ Days per week: _____

b. Intermittent Basis (sporadic, unpredictable in nature)

Did or will condition cause episodic flare-ups on an INTERMITTENT basis preventing the employee from performing his/her job functions? 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 six months**.

Example: 2 times per day lasting approximately 1 hour per episode.

Episodes of incapacity are estimated to occur _____ times per (day week month) and are likely to last approximately _____ (hours days) per episode.

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