

## Certification of Health Care Provider Employee Health Condition *Family and Medical Leave Act of 1993 ("FMLA")*

### SECTION I: For Completion by the EMPLOYEE

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section I before giving this form to your medical provider. The FMLA permits the University 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. This Certification 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 completed form must be returned to the University's Absence Management Team **within 15 calendar days**. 29 C.F.R. § 825.305(b).

Employee Name:

University Employee Identification Number:

I hereby authorize a representative of the University of Utah Division of Human Resources to contact my Health Care Provider for purposes of clarification and/or authentication of this Certificate of Health Care Provider.

Signature of Employee

Date

### SECTION II: For Completion by the HEALTH CARE PROVIDER

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Please 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. In compliance with the Genetic Information Nondiscrimination Act of 2008 (GINA), please do not include any statements about genetic testing or any genetic information or family history information in response to this request for medical information. Please be sure to sign the form on the last page.

Provider Name:

Type of Practice/Specialty:

Business Address:

Telephone:

Fax:

### PART A: MEDICAL FACTS TO DETERMINE IF SERIOUS HEALTH CONDITION EXISTS

Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition (if known): \_\_\_\_\_

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

☐ No ☐ Yes If yes, dates of admission: \_\_\_\_\_

2. Date(s) you treated the patient for condition:

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

☐ No ☐ Yes If yes, are appointment times available outside the employee's work hours? ☐ No ☐ Yes

4. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

5. 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:
6. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, expected delivery date: \_\_\_\_\_
7. Provide other relevant medical facts 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):
8. Is the employee unable to perform any of his/her job functions due to the condition:  
☐ No ☐ Yes If yes, identify the job functions the employee is unable to perform (if a list of the employee's essential functions or a job description is not provided, please answer this question based upon the employee's own description of his/her job functions):

#### **PART B: AMOUNT OF LEAVE NEEDED**

9. Will the employee be incapacitated<sup>1</sup> for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  
☐ No ☐ Yes If yes, estimate the beginning and ending dates for the period of continuous incapacity:
10. Will the employee need to attend follow-up treatment appointments because of the employee's medical condition?  
☐ No ☐ Yes If yes, estimate treatment schedule, if any, including the dates or frequency of any scheduled appointments and the time required for each appointment, including any recovery period:
11. Will the employee need to work part-time or on a reduced schedule because of the employee's medical condition?  
☐ No ☐ Yes If yes, estimate the part-time or reduced work schedule the employee needs, including hours per day and days per week and an estimate of beginning and end dates:

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<sup>1</sup> "Incapacity" for purposes of the FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, and recovery there from.

12. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

☐ No ☐ Yes If yes, explain why it is medically necessary for the employee to be absent from work during the flare-ups:

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: \_\_\_\_\_ time(s) per \_\_\_\_\_ (week/month/year)

Duration: \_\_\_\_\_ hour(s) or \_\_\_\_\_ day(s) per episode

**PART C: ADDITIONAL INFORMATION**

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**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**