

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

SECTION I: For Completion by the EMPLOYEE and FAMILY MEMBER

***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:

Name of Family Member for whom you will provide care:

Relationship to You:

If son or daughter, provide date of birth:

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

Signature of Employee

Date

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 Patient (or Patient's legal guardian)

Date

SECTION II: For Completion by the HEALTH CARE PROVIDER

***INSTRUCTIONS to the HEALTH CARE PROVIDER:** Our employee has requested leave under the FMLA to care for a family member who is your patient. 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 (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

- 8. Will the patient be incapacitated¹ 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: _____
- 9. During this time, will the patient need care from family members?
 No Yes If yes, explain the care needed by the patient and why such care is medically necessary: _____

¹ "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 therefor, and recovery therefrom.

10. Will the patient need to attend follow-up treatment appointments because of the 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 patient require care on an intermittent or reduced schedule basis, including time for recovery?

No Yes If yes, estimate the hours the patient needs care or reduced work schedule the employee needs, including hours per day and days per week and an estimate of beginning and end dates:

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

12. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?

No Yes If 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: _____ time(s) per _____ (week/month/year)

Duration: _____ hour(s) or _____ day(s) per episode

Explain the care needed by the patient during episodic flare-ups, and why such care is medically necessary:

PART C: ADDITIONAL INFORMATION

Signature of Health Care Provider

Date