FAMU | OFFICE OF HUMAN RESOURCES
FLORIDA AGRICULTURAL & MECHANICAL UNIVERSITY

# Family and Medical Leave Act (FMLA)
# Certification of Health Care Provider Form for
# Family Member's Serious Health Condition

**Instructions for Employee**: Please complete Section I before giving this form to your family member or his/her health care provider. You are required to submit a timely, complete, and sufficient medical certification to support a request for FMLA leave. This form will provide the Office of Human Resources with information needed to determine if your leave request is for a qualifying reason under the FMLA. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **This form should be returned within fifteen (15) calendar days of the request for this information.** If additional time is needed to complete and return the form, please contact the Office of Human Resources at (850) 599-3611 and request to speak with the FMLA Administrator. You will need to provide a reason for the delay and the date when the certification will be provided. You may return the form in person, by mail, or by fax. The fax number is (850) 412-5566. If sending by fax, please include a fax cover sheet marked "CONFIDENTAL" and address the fax to the Office of Human Resources.

## SECTION I – EMPLOYEE INFORMATION

Employee's Name:

Name of family member for whom you will provide care:

| Relationship of family member to you: | If family member is your child, date of birth: |
|---|---|

If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability? ☐ Yes ☐ No

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

_____

_____

_____

**I certify that the information that I provided above is true and correct.**

| **Signature of Employee:** | **Print Name:** | **Date:** |
|---|---|---|
| | | |

## SECTION II - HEALTH CARE PROVIDER INFORMATION

**Instructions for Health Care Provider:** The employee listed above has requested leave under the FMLA to care for 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 "indefinite," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

Provider's Name:

Business Address:

Type of Practice/Medical Specialty:

| Phone: | Fax: |
|---|---|

## PART A: MEDICAL FACTS

| 1. Approximate date condition commenced: | Probable duration of condition: |
|---|---|
| _____ | From: _____ To: _____ |

2. On page 5, describes what is meant by a "serious health condition" under the FMLA. Does the patient's condition qualify under any of the categories described? ☐ Yes ☐ No

If yes, which type of serious health condition listed on page 5 applies: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
☐ Yes ☐ No

If yes, dates of admission: _____

Date(s) you treated patient for condition: _____

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

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
☐ Yes ☐ No

If yes, state the nature of such treatments and expected duration of treatment:

_____

_____

_____

3. Is the medical condition pregnancy? ☐ Yes ☐ No If yes, expected delivery date: _____

4. Describe other relevant medical facts, if any, related to the condition for which the patient 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 CARE NEEDED

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

If yes, estimate the start and end dates for the period of incapacity: Start: _____ End: _____

During this time, will the patient need care? ☐ Yes ☐ No

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

_____

_____

2. Will the patient require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Date: _____ Amt. of Time: _____ Date: _____ Amt. of Time: _____

Date: _____ Amt. of Time: _____ Date: _____ Amt. of Time: _____

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

_____

_____

3. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

Estimate the hours the patient needs care on an intermittent basis, if any:

Hour(s) per day: _____ # Days per week: _____ From: _____ To: _____

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

_____

_____

4. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

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

Does the patient need care during these flare-ups? ☐ Yes ☐ No

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

_____

_____

_____

_____

**ADDITIONAL INFORMATION (Identify question number with your additional answer):**

_____

_____

_____

_____

_____

_____

_____

| **Signature of Health Care Provider:** | **Print Name:** | **Date:** |
|---|---|---|
| | | |

# Serious Health Conditions

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

**1. Inpatient Care**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

**2. Incapacity of More Than 3 Consecutive Days and Continuing Treatment by a Health Care Provider**

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(a) **Treatment two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provided, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; OR

(b) **Treatment** by a health care provider on **at least one occasion** which results in **a regimen of continuing treatment** under the supervision of the health care provider (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). Note: This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

**3. Pregnancy**

A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.

**4. Chronic Conditions Requiring Treatment**

A chronic condition which:

(a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

**5. Permanent/Long-Term Conditions Requiring Supervision**

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

**6. Multiple Treatments (Non-Chronic Conditions)**

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).