ASU Human Resources

Type: Intermittent or Continuous DOH: _____/_____/_____

FML BEG: _____/_____/_____ FML END: _____/_____/_____ END REASON: _____

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

Office of Human Resources
APPALACHIAN STATE UNIVERSITY

SECTION 1: For Completion by the EMPLOYEE

INSTRUCTIONS: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Employee name: _____ Banner _____

Mailing Address: _____City_____State_____Zip_____

Best Phone number to contact you: _____ Home Mobile Work (Circle one)

Department:_____ Email Address: _____

Employment Status: ____Permanent Full-Time ____ Permanent Part-Time ____ Temporary

How long have you been employed? or Hire Date _____

Name / relationship of Family member for whom you will provide care:

_____

Type of care you will be providing (use back of form if additional space is needed):

_____

_____

Date Leave is to begin: _____ Date Leave is expected to end: _____

Employee Signature: _____ Date: _____

SECTION 2: For Completion by the SUPERVISOR

INSTRUCTIONS: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section 2 before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employee's job title: _____Regular work schedule: _____

Employee's essential job functions: _____

_____

Supervisor name (Print) _____Email_____

Supervisor Signature _____ Phone_____

Employee Name: _____ **PATIENT Name:** _____

SECTION 3: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

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Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____Fax :(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___Yes.
If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___Yes.
If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

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

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

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: _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other 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):

_____
_____
_____

Employee Name: _____ **PATIENT Name:** _____

PART B: AMOUNT OF LEAVE NEEDED

4. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition including any time for treatment and recovery? ___No ___Yes.

Estimate the beginning and ending dates for the period of incapacity: ____/____/____ ____/____/____

During this time will the patient need care? ___No ___Yes.

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

_____

_____

5. Will the patient require follow-up treatments, including any time for recovery? ___No __Yes.

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

_____

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

_____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
___No ___ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:
_____hour(s) per day; _____ days per week from ____/____/____ through ____/____/____

Explain the care needed by the patient on this intermittent basis and why such care is medically necessary:

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from performing 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 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

_____ _____

Signature of Health Care Provider **Date**

PLEASE RETURN COMPLETED FORM TO:
Carolyn Bosley
Leave Management Administrator
Appalachian State University **Phone: (828) 262-6488**
ASU Box 32010 **Fax: (828) 262-6489**
Boone, NC 28608

SECTION 4: For Completion by Appalachian State University Human Resource

FML is applicable in this case: _____YES _____ NO

Approved by: _____ Designation Letter ____/____/____