Certification of Healthcare Provider for Employee's Serious Health Condition

PURPOSE: For employees on medical leave who did not qualify for, or have exhausted, Family and Medical Leave. The named employee has requested a medical leave of absence. This form will provide the University with information needed to determine how long and what type of leave the employee will need.

INSTRUCTIONS:

HEALTH CARE PROVIDER: **Please DO NOT disclose the employee's underlying diagnosis.** Your patient (our employee) has requested leave for their serious health condition. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the employee. Be as specific as possible; terms such as "indefinite," "unknown," or "indeterminate" *are not sufficient* to determine leave coverage. Limit your responses to the condition for which the employee is seeking medical leave. Be sure to sign and date the form.

EMPLOYEE: Submit timely, complete, and sufficient medical documentation to support your request. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your requested leave.

Please complete form and have the employee return it, or fax it to the University Representative named herein.

SECTION I: To be completed by Employee's DEPARTMENT REPRESENTATIVE

EMPLOYEE'S NAME		EMPLOYEE'S JOB TITLE
NAME OF DEPARTMENT REPRESENTATIVE		MAILING ADDRESS OF DEPARTMENT REPRESENTATIVE
TELEPHONE	FAX	E-MAIL

SECTION II – To be completed by HEALTH CARE PROVIDER

PART A: MEDICAL FACTS*

(1) Probable DURATION of condition: **From:** _____ **To:** _____

(2) Does the employee have a serious health condition as described on Page 2? ☐ Yes ☐ No

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

PART B: AMOUNT OF LEAVE NEEDED

(3) Is it necessary that the employee be on leave for a single continuous period of time due to his/her medical condition, including time for treatment and recovery? ☐ Yes ☐ No

If **yes**, estimate the dates for the period of incapacity: **From:** **To:**

PART C: INTERMITTENT LEAVE – Complete only if leave is on an ***intermittent basis*** or a ***reduced schedule***.

(4) Will the medical condition cause **episodic flare-ups** that make it medically necessary to leave work **intermittently** or work a **reduced schedule**? ☐ Yes ☐ No

a) Reduced schedule: Work no more than: _____ Hours/Day _____ Days/Week From: _____ To: _____

b) Intermittent leave: Frequency: _____ Times, per ☐ Week(s) ☐ Month(s)

Duration: ☐ _____ **Hour**(s) per episode **- OR -** ☐ _____ **Day**(s) per episode

c) Flare-ups may occur: **From:** **To:**

SECTION III: INFORMATION & SIGNATURE OF HEALTH CARE PROVIDER

PROVIDER'S NAME	ADDRESS OR STAMP
TELEPHONE	FAX
SIGNATURE OF HEALTH CARE PROVIDER	DATE

*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. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

RESET

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 Plus 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 provider, 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 (only if exhausted PDL and/or FMLA)**
   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), or kidney disease (dialysis).