CERTIFICATION OF HEALTHCARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)

UF | Human Resources
UNIVERSITY of FLORIDA

SECTION 1: FOR COMPLETION BY THE EMPLOYEE

Instructions to the Employee: Please complete Section 1 before giving this form to your family member or their medical provider. The Family and Medical Leave Act (FMLA) permits an employer to require that you submit 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. You must be provided at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b). 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. 20 C.F.R. § 825.313.

Employee Name:	**UFID:**	**College/Division:**
Name of Family Member:		**Relationship:**

I expect to absent from work to provide care for my family member:

☐ **For a continuous period of**_____ ☐ *day(s)* ☐ *week(s)* ☐ *month(s)*

☐ **Intermittently,**_____–_____ ☐ *hour(s)* ☐ *day(s)* ***every*** _____–_____ ☐ *day(s)* ☐ *week(s)* ☐ *month(s)*

You are expected to clearly communicate any anticipated absences to your supervisor in a timely manner. You may choose to be absent less frequently than indicated by your family member's healthcare provider.

Employee Signature **Date**

SECTION 2: FOR COMPLETION BY THE HEALTHCARE PROVIDER

Instructions to the Health Care Provider: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts. Limit your responses to the condition for which the patient needs or would benefit from the employee's care. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b). Please include your signature on the last page.

Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Be as specific as you can and provide an estimate based upon your medical knowledge, experience and examination of the patient: terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to confirm an FMLA designation.

Provider Name:	**Type of Practice/Medical Specialty:**
Business Address:	
Telephone:	**Fax:**

PART A: MEDICAL FACTS

1. Description of condition:_____

Approximate date condition commenced:_____

Probable duration of condition (as of date Medical Certification is completed): _____

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

☐ No ☐ Yes If yes, dates of admission:_____

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

Does the patient's condition require treatment visits at least twice per year? ☐ No ☐ Yes

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

PART B: AMOUNT OF CARE NEEDED

When answering these questions, please consider 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. Explain the care needed by the patient and why such care is medically necessary or beneficial:

_____

_____

_____

_____

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

If yes, estimate the dates of the period of incapacity:_____
During this time, will the patient need or benefit from care? ☐ No ☐ Yes
If yes, provide an estimate of the duration and frequency that the patient would regularly need/benefit from care:

_____ – _____	☐ *hour(s)* ☐ *day(s)*	***every***	_____ – _____	☐ *day(s)* ☐ *week(s)* ☐ *month(s)*

3. Will the patient need to attend follow-up treatment appointments? ☐ No ☐ Yes

If yes, estimate the treatment schedule (i.e., time required for each appointment and recovery):

_____

4. Will the condition cause flare-ups that impair normal daily activities? ☐ No ☐ Yes

If yes, provide an estimate of the duration and frequency of care the patient would require during a flare-up:

_____ – _____	☐ *hour(s)* ☐ *day(s)*	***every***	_____ – _____	☐ *day(s)* ☐ *week(s)* ☐ *month(s)*

SECTION 3: ADDITIONAL INFORMATION

Include any further relevant information. If supplementing an item above, identify the question number with your additional answer.

Signature of Health Care Provider **Date**

Any questions concerning how to complete this form or the Family Medical Leave Act, more generally, can be addressed to your UFHR-Central Leave Team at (352) 392-2477 or central-leave@ufl.edu.

The completed form can be sent via secure fax to 352-392-5166, emailed to fmla@hr.ufl.edu, dropped off in person or mailed to 903 W University Avenue, PO Box 115007, Gainesville, FL 32611-5007

Keep a copy of this form for your personal records.