File: GCBE-F-2

REQUEST FOR FAMILY AND MEDICAL LEAVE
Certification of Health Care Provider for Employee's Serious Health Condition

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your 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 due to your own serious health condition. 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. You have 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Please print or type

Employee Name: _____
First Middle Last

Employee ID #: _____

Address: _____
Street City State Zip

School/Department/Position:_____

I certify that the information provided on this form is true. I understand that making false statements on this form or any other related forms is grounds for discipline up to and including dismissal.

_____ _____
Employee's Signature Date

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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. Please be sure to sign the form on the last page.

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:_____

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

Was medication, other than over-the-counter medication, prescribed? ___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: _____

Date patient will be physically unable to continue her contractual responsibilities: _____

3. Use the job description provided to answer this question. If the employee fails to provide a job description, answer the questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition:
____No ___Yes

If yes, identify the job functions the employee is unable to perform:

_____

_____

4. 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)_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated 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 incapacity: _____

6. Will the employee require follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

If yes, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes

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

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____hour(s) per day; _____days per week from _____ through_____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes

Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____ Yes

If yes, explain: _____

_____

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**