FMLA CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S PREGNANCY

Name _____

Health Care Provider,
Please return this form
by _____ to:

Address _____

_____

_____

Telephone (____) _____ FAX: (____) _____

SECTION I: Instructions for Completion by DEPARTMENT

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. **Please complete the above return address and Section I before giving this form to your employee.** Departments must maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

IMPORTANT: UPON RECEIPT FROM HEALTH CARE PROVIDER, FAX A COPY OF THIS COMPLETED DOCUMENT TO: HR DISABILITY & LEAVES PROGRAM MANAGEMENT UNIT AT 480.993.0007

Employee's name _____

Employee's job title: _____

Employee's regular work schedule: _____

Department name: _____

Department contact: _____

Provided to employee on: _____

(**MUST BE PROVIDED) Employee's essential job functions**:

_____

_____

_____

_____

Check if Job Description, with essential functions, is attached: ☐

SECTION II: Instructions for Completion by the EMPLOYEE

Please type/print your name on the top of page 2 before giving this form to your medical provider. The FMLA permits Arizona State University ("ASU") 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. If requested by ASU, your response is required to obtain or retain the benefit of FMLA protections. **Failure to provide a complete and sufficient medical certification by the date indicated above may result in a denial of your FMLA request.** These same obligations apply to any and all ASU requests for periodic re-certification.

ENSURE YOUR HEALTH CARE PROVIDER COMPLETES SECTION III & RETURNS THIS FORM BY THE DATE INDICATED

Employee/Patient Name: _____
First **Middle** **Last**

SECTION III: Instructions for Completion by 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: (Print) _____

_____

Type of practice / Medical specialty: (Print) _____

Telephone: (_____) _____ FAX :(_____) _____

PART A: MEDICAL FACTS

1. Medical diagnosis for which employee/patient is requesting leave: _____

   Approximate date condition commenced: _____

   Probable duration of 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:_____

   _____

   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 ☐ No ☐ Yes

   If so, 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. **Use the information provided by the employer in Section I to answer this question**. If the employer fails to provide a list of the employee's essential functions or a job description, answer these 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 so, 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 and absent from work for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ No ☐ Yes.

   If so, estimate the beginning and ending dates for the period of incapacity:_____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☐ Yes.

   If so, 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 the job functions?

   ☐ No

   ☐ Yes; Is it medically necessary for the employee to be absent from work during the flare-ups?

   ☐ No

   ☐ Yes. Please 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: _____ time(s)

   Every: _____ week(s) or _____ month(s)

   Lasting: _____ hour(s) per episode or _____ day(s) per episode

ADDITIONAL INFORMATION

Attach additional sheets as needed. Please include your provider name and the employee's name on each page and identify the question number with each of your answers.

_____ _____ _____

Health Care Provider's Name (Print) Health Care Provider's Signature Date

HEALTH CARE PROVIDER: PLEASE RETURN THIS FORM TO THE ADDRESS AT THE TOP OF PAGE 1