FMLA Certification of Health Care Provider for Employee's Serious Health Condition

Instructions to the health care provider

Complete section III of this form and return to employer by_____.

Employer name: Arizona State University

Department contact name:_____

Address:_____

Telephone: _____ **Fax:** _____

Section I: ASU department to complete

Instructions: The Family and Medical Leave Act provides that an employer may require an employee seeking FMLA protections because of a need for leave because of a serious health condition to submit a medical certification issued by the employee's health care provider.

Complete the above return address and Section I before giving this form to your employee. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. 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 or 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.

Important: Upon receipt from the health care provider , fax the completed document to HR Disability and Leaves Program Management at 480-993-0007.

Employee's name: _____

Employee's job title: _____

Department name: _____

Department contact: _____

Employee's regular work schedule: _____

Provided to employee on: _____

Employee's essential job functions: _____

_____

_____

Check if job description, with essential functions, is attached ☐

Section II: Employee to complete:

Instructions: Complete Section II before giving this form to your medical provider. The FMLA permits ASU to require that you submit a timely, complete and sufficient medical certification to support a request for FMLA leave because of your own serious health condition. If requested by ASU, 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. ASU must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b). These same obligation apply to any and all ASU requests for periodic re-certification.

Name — first, middle, last: _____

ENSURE YOUR HEALTHCARE PROVIDER COMPELTES SECTION III & RETURNS THIS FORM BY THE DATE INDICATED.

SECTION III: Health care provider to complete:

Instructions: 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. 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 be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice or medical specialty: _____

Telephone: _____ Fax: _____

Part A: Medical Facts

1. Medical diagnosis for which employee or 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: _____
   - Dates you treated the patient for condition: _____
   - Will the patient need to have treatment visits at least twice per year due to the condition?
   - Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes
   - Was the patient referred to other health care providers such as physical therapist 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 or her job functions.
   - Is the employee unable to perform any of his or 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 for a single continuous period of time due to a medical condition, including any time for treatment and recovery? ☐ No ☐ Yes
   - If so, estimate the beginning and ending dates for the period of incapacity:
     Beginning:_____ Ending: _____
6. Will the employee need to attend follow-up treatments, work part-time or work 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: _____ hours per day;_____ days per week from_____ through _____
7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his or her job functions? ☐ No ☐ Yes
   - Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ No ☐ Yes
     - If so, 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 during the next six months. For example, one episode every three months lasting one to two days.

Frequency:_____ times per_____ week(s)_____ month(s)

Duration:_____ hours or_____ day(s) per episode

Health care provider — print name: _____

Health care provider signature:_____
Date:_____

Additional information

Attach additional sheets as needed. Include your provider name and the employee's name on each page and identify the question number with each of your answers. Return this form to the address at the top of page one.