Creighton UNIVERSITY

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

Employer contact: Toni Parsley **FAX # (402) 280-5516**

FOR COMPLETION BY EMPLOYEE:

Employee Name:____

Regular work schedule:____

Essential job functions:____

FOR COMPLETION BY 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.

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ____

   Probable duration of condition: ____

2. Describe 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):

____

____

____

Mark below as applicable:

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:

____

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 yes, expected delivery date:_______________________

3. Use the information provided by the employee to answer this question.

Is the employee unable to perform any of his/her essential job functions due to the condition: ____ No ____ Yes
If yes, identify the job functions the employee is unable to perform:

____

PART B: AMOUNT OF LEAVE NEEDED (Please choose applicable option):

1. 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 so, estimate the beginning and ending dates for the period of incapacity: ______________________________

or

2. 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______________________

or

3. Will the condition cause episodic or intermittent 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 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 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

Provider's name and business address: ____

Type of practice / Medical specialty: ____

Telephone: (________) _____________________________ Fax :(_________) ____________________________

____ _______________________________________

Signature of Health Care Provider **Date**

Rev. 05/2009