Creighton UNIVERSITY

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

Employer contact: Lenora Salts **FAX # (402) 280-3113**

FOR COMPLETION BY EMPLOYEE BEFORE GIVING FORM TO HEALTH CARE PROVIDER:

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. Please 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 able to perform any of his/her essential job functions due to the condition: No______Yes _____

If no, 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 yes, 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 :(_________) ______________________________________

____ ____