Creighton UNIVERSITY

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

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

FOR COMPLETION BY THE EMPLOYEE:

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____ _____
Employee Signature Date

FOR COMPLETION BY HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs 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: _____

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: _____

Was medication, other than over-the-counter medication, prescribed?____No_____Yes.

Will the patient need to have treatment visits at least twice per year due to the condition?_____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: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

1. A). Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?

   ___No___Yes. If yes, please complete sections #2 and #6.

   B). Will the patient require follow-up treatments, including any time for recovery?

   ___No___Yes. If yes, please complete sections #3 and #6.

   C). Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

   ___No___Yes. If yes, please complete sections #4 and #6.

   D). Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?_____No_____Yes. If yes, please complete sections #5 and #6

2. Estimate the beginning and ending dates for the period of incapacity:_____

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

   _____

   _____

4. Estimate the hours the patient needs care on an intermittent basis, if any:

   _____hour(s) per day;_____days per week from_____through_____

5. 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

   Does the patient need care during these flare-ups?_____No_____Yes.

6. Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax :(_____) _____

_____ _____

Signature of Health Care Provider **Date**