UCF | Human Resources

UNIVERSITY OF CENTRAL FLORIDA

University of Central Florida Certification of Health Care Provider Form for a Family Member's Serious Health Condition
Family and Medical Leave Act

University of Central Florida, Human Resources, 3280 Progress Drive, Suite 100, Orlando, FL 32826
Phone: 407-823-2771; Fax: 407-823-1095

THIS FORM MUST BE FORWARDED DIRECTLY TO THE HUMAN RESOURCES DEPARTMENT.

Instructions to Supervisor/Dean/Director: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections, because of a need for leave to care for a covered family member with a serious health condition, to submit a medical certification issued by the health care provider of the covered family member. You may not ask the employee to provide more information than allowed under the FMLA regulations. The University must generally maintain records and documents relating to medical certifications, recertification, or medical histories of employees' family members, created for FMLA purposes, as confidential medical records in separate files/records from the usual personnel files, with an FMLA Administrator.

SECTION I: For Completion by the Employee. Please complete Section I before giving this form to your family member or his/her medical provider. The FMLA permits the University to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. The University must give you at least 15 calendar days to return this form.

Your name: (Last) _____ (First) _____ (Middle) _____
Name of family member for whom you will provide care: _____ Relationship to you: _____
If family member is your son/daughter, date of birth: _____
Describe care you will provide to family member and estimate leave needed to provide care: _____

_____

_____

(*UCF ID*) _____ (*Employee Signature*) _____ (*Date*) _____

SECTION II: For Completion by the Health Care Provider. The employee listed above has requested medical leave under FMLA to care for your patient. Answer, fully and completely, all applicable parts. Your answer should be your best estimate based on 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 and the care they need to provide to your patient. *Do not provide information about genetic tests or genetic services as defined in 29 C.F.R § 1635.3*. Please be sure to sign the form on the last page.

Provider's name and business address: _____
Type of practice/Medical specialty: _____ State of FL License Number: _____
Telephone: (____) _____ Fax: (____) _____

PART A: Medical Facts

1. **Approximate date condition commenced**: _____
Probable duration of condition ***(Please estimate dates; do not state unknown or indeterminate)***: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? YES ☐ NO ☐
If so, date(s) 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? YES ☐ NO ☐

Was medication, other than over-the-counter medication, prescribed? YES ☐ NO ☐

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? YES ☐ NO ☐
If yes, state the nature of such treatments and expected duration of treatment: _____

_____

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2. **Is the medical condition pregnancy?** YES ☐ NO ☐ If yes, expected delivery date: _____

3. **Describe diagnosis and other relevant medical facts related to the condition for which your 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 and Leave Needed (Please be specific on amount of time and/or dates. Keep in mind your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical or psychological care.)

4. **Will the patient be incapacitated for a *single continuous period* of time due to his/her medical condition, including any time for treatment and recovery?** YES ☐ NO ☐ If yes, estimate the beginning and end dates for the period of incapacity. ***Please do not state unknown or indeterminate***. _____

During this time, will the patient need care? YES ☐ NO ☐

Explain the care needed by the patient and why such care is medically necessary: _____

_____

_____

5. **Will the patient require follow-up treatments, including any time for recovery?** YES ☐ NO ☐

If yes, are the treatments medically necessary? YES ☐ NO ☐ Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

_____

_____

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

_____

6. **Will the patient have flare-ups of their condition?** YES ☐ NO ☐ If yes, how often? _____

If yes, how long will each episode last? _____ (Please note if hours or days)

If yes, explain the care the patient will need during each flare-up, and why such care is medically necessary:

_____

_____

Based on your patient's treatment plan, which of the following are you recommending for our employee to care for your patient:

Not work at all (patient requires full time care): ☐ **Work intermittently:** ☐ **Work a reduced work schedule:** ☐

If our employee could care for the patient on an intermittent or reduced work schedule basis during the patient's recovery (e.g. one day off per week for six months), please estimate the hours/days your patient needs care from our employee:

_____hour(s) per day; _____ days per week from _____ through _____ (dates)

ADDITIONAL INFORMATION: Identify Question Number with Your Additional Answer (attach separate sheet if necessary):

_____

_____

_____

(Signature of Healthcare Provider) _____ *(Date)* _____

Revised February 2017