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 due to a serious health condition, to submit a medical certification issued by the employee’s health care provider. 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, created for FMLA purposes, as confidential medical records in separate files/records from the usual personnel files, with an FMLA Administrator. When providing this form to the employee, attach a copy of the employee’s position description.

SECTION I: For Completion by the Employee. Please complete Section I before giving this form to your 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 due to your own 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)

Dates you are requesting leave: to Employee’s Job Title:

Employee’s essential job functions (Attach a copy of your position description):

(UCF ID)   (Employee Signature)      (Date)

SECTION II: For Completion by the Health Care Provider. Your patient has requested leave under the FMLA. 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. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee’s family members 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: ____________________________________________
University of Central Florida Certification of Health Care Provider Form for Employee’s Serious Health Condition
Family and Medical Leave Act

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

Is Surgery Scheduled? YES ☐ NO ☐ If yes, surgery date: ____________________________

3. I have reviewed the patient’s position description: YES ☐ NO ☐ If there is not a position description attached to this form, please review the employee’s essential job functions as noted by the employee on page 1 of the form.

Is the employee able to perform his/her job functions due to the condition: YES ☐ NO ☐
If no, identify the job functions the employee is unable to perform:

________________________________________________________________________

________________________________________________________________________

4. Describe diagnosis and other relevant medical facts 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 (Please be specific on amount of time and/or dates)

5. 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? YES ☐ NO ☐ If yes, estimate the beginning and end dates for the period of incapacity. Please do not state unknown or indeterminate. ____________________________

6. Will the employee need to attend follow-up treatment appointments due to employee’s medical condition? YES ☐ NO ☐
If yes, are the treatments medically necessary? YES ☐ NO ☐ Estimate treatment schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period: ____________________________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? YES ☐ NO ☐ If yes, is it medically necessary for the employee to be absent from work during flare-ups? YES ☐ NO ☐
If yes, 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: May occur _______ times every ☐ week ☐ month
Duration: May last _________ hours per episode or May last _________ day(s) per episode

Based on the employee’s treatment plan, it is medically necessary for the employee to:

Not work at all: ☐ Work intermittently: ☐ Work a part-time/reduced work schedule: ☐

Estimate the part-time hours or reduced work schedule the employee needs, if any:

May work: _______ 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)

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