Human Resources

UNIVERSITY OF CENTRAL FLORIDA

University of Central Florida Certification of Health Care Provider Form for Employee'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 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): ________________

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(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: ________________

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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:

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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):

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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: ________________

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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):

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(Signature of Healthcare Provider) *(Date)*

Revised February 2017