



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

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University of Central Florida, Human Resources, 12565 Research Parkway, Suite 360, Orlando FL 32826
Phone: 407-823-2771; Fax: 407-823-1095

SECTION I: 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. Employers must generally maintain records and documents relating to medical certifications, recertification's, 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 II: For Completion by the Employee Instructions to the Employee: Please complete Section II 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: _____
First Middle Last

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

Relationship of family member to you: _____

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

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

Empl ID Employee Signature Date

SECTION III: For Completion by the Health Care Provider

Instructions to 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 are needed to provide to your patient. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

License Number Issued by the State of Florida: (if different state list name of state and License number) _____

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

PART A: Medical Facts

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes ____ No ____.

If so, 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? Yes ____ No ____.

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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 so, state the nature of such treatments and expected duration of treatment:

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, basic medical, hygienic, nutritional, safety, transportation needs, physical or psychological.)

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: _____
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 treatment, 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: _____

7. Based upon your patient's medical history and your knowledge of the medical condition could our employee 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):

Yes ___ No ___. If yes, estimate the hours/days your patient needs care from our employee on an intermittent basis:
_____ hour(s) per day; _____ days per week from _____ through _____ (dates)

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

Not work (patient requires full time care): _____ work intermittently: _____ work a reduced work schedule: _____

ADDITIONAL INFORMATION: Identify Question Number with Your Additional Answer, attach addition sheet if necessary :

Signature of Health Care Provider

Date

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