UCF Human Resources
UNIVERSITY OF CENTRAL FLORIDA

UCF Certification of Healthcare Provider Form for a ***Family Member's*** Serious Health Condition under the Family and Medical Leave Act

University of Central Florida, Human Resources, 12201 Research Pkwy #200, Orlando, FL 32826
Phone: 407-823-2771 – Confidential Fax: 407-882-9023

THE COMPLETED FORM MUST BE FORWARDED DIRECTLY TO UCF HUMAN RESOURCES.

SECTION I – EMPLOYEE COMPLETES

Please complete and sign Section I before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. § 825.305. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

Your name:_____ _____ _____
Last *First* *Middle*

Patient name:_____ _____ _____
Last *First* *Middle*

Relationship to you: _____ If child, date of birth _____ Dates requested for leave:_____ to _____

Briefly describe the care you will provide to your family member:

☐ Assist with basic medical, hygienic, nutritional, or safety needs ☐ Transportation ☐ Physical Care ☐ Psychological Comfort

☐ Other:_____

Give your best estimate of the amount of time away from work needed to provide the care described:

_____

_____ _____ _____
UCF ID ***Employee Signature*** ***Date***

Purpose and Use Statement: 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.

SECTION II – HEALTH CARE PROVIDER COMPLETES

The employee listed above has requested medical leave under FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. Please provide your contact information, state license number, and complete all relevant parts of this Section. Your answers 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. *Note*: *Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b)*. Please be sure to sign the form on the next page.

Provider's name and business address: _____

Type of practice/Medical specialty:_____ State License Number: _____

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

PART A: Medical Facts Please provide complete information for the determination of eligibility for leave under FMLA and UCF policy.

1. Approximate date condition commenced or will commence: _____

   Provide your **best estimate** of how long the condition lasted or will last: _____

   For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)*. _____

   _____

   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: _____

   _____

   _____

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

3. **Describe diagnosis and other relevant medical facts related to the patient's 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 the 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. **CONTINUOUS INCAPACITY**

Will the patient be incapacitated for **a single continuous period** including any time for treatment(s) and/or recovery? YES ☐ NO ☐

If yes, estimate the beginning and end dates for the period of patient incapacity. (*Please do not state unknown or indeterminate.*)

Beginning Date:_____ through End Date _____

5. **INTERMITTENT INCAPACITY OR CARE**

Due to the patient's medical condition, is it medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically) such as for appointments or any episodes of incapacity such as episodic flare-ups? YES ☐ NO ☐

If yes, provide your ***best estimate*** of how often (frequency) and how long (duration) the episodes of incapacity will likely last below.

A. Planned Absences: Includes scheduled or expected follow-up appointments and medical treatments. (Enter numbers in applicable fields.)

Appointment Frequency:

Up to _____time(s) (*select one*) ☐ every_____ week(s) ***OR*** ☐ every _____ month(s) ***OR*** ☐ each year.

Appointment/Recovery Duration:

Each may last up to (*select one*) ☐ _____ hour(s) ***OR*** ☐ _____ day(s)

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

_____

B. Unplanned Absences: Such as flare-ups which would require the employee to care for the patient. (Enter numbers in applicable fields.)

Episode Frequency:

May occur up to_____ times (*select one*) ☐ every _____week(s) ***OR*** ☐ every_____ month(s)

Episode Duration:

Each episode may last (*select one*) ☐ _____ hour(s) ***OR*** ☐_____day(s)

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

_____

_____

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

_____

_____

_____

_____

Signature of Health Care Provider _____ ***Date:*** _____