UCF | Human Resources

UNIVERSITY OF CENTRAL FLORIDA

University of Central Florida Certification of Healthcare 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: 407-882-9023

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

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 (provide a copy of your position description): _____

_____

(*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.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that information about the health condition of your patient may be provided as needed to complete the certification request.

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: _____

   _____

   _____

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

3. **Is Surgery Scheduled?** YES ☐ NO ☐ If yes, surgery date: _____

4. **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: _____

   _____

   _____

5. **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)

6. **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.*) _____

7. **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: _____

   _____

   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)

8. **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 -or- ☐ month
   Duration: May last _____ hour(s) ☐ -or- day(s) ☐ per episode

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

_____

_____

_____

_____

_____

_____

(Signature of Healthcare Provider) _____ (Date) _____