UCF | **Human Resources**

UNIVERSITY OF CENTRAL FLORIDA

University of Central Florida Certification of Health Care Provider Form for a Family Member'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) _____

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

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

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

_____

_____

(*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. 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 need to provide to your patient. *Do not provide information about genetic tests or genetic services 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. **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 may include assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical or psychological care.)

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. ***Please do not state unknown or indeterminate***. _____

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 treatments, 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 require care on an intermittent or reduced work schedule basis during the patient's recovery (e.g. one day off per week for six months), please estimate the hours/days your patient needs care from our employee:**

_____hour(s) per day; _____ days per week from _____ through _____ (dates)

7. **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:

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

(Signature of Healthcare Provider) _____ *(Date)* _____