UCF Human Resources
UNIVERSITY OF CENTRAL FLORIDA

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

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

SECTION I – EMPLOYEE COMPLETES

Please complete Section I before giving this form to your medical 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 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. 29 C.F.R. §825.305

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

Dates you are requesting leave to begin ____/____/____ and end ____/____/____Regular Work Schedule:_____

Job Title:_____ Attach job description ***or*** state essential job functions:_____

_____

_____

_____ _____ _____/_____/_____
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

Your patient has requested leave under the FMLA. Please provide your contact information, state license number, and complete all relevant parts of this Section. 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. *Note*: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. *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 all information for the determination of eligibility for leave under FMLA and UCF policy.

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: _____

   _____

   _____

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

2. **Is surgery scheduled (or taken place)?** 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.

   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:_____

   _____

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):

   _____

   _____

PART B: Amount of Leave Needed

Related to employee's medical condition only, please be specific on the amount of time and/or dates of incapacity in the applicable category.

5. **CONTINUOUS Leave**

   Will the employee be **incapacitated for a single continuous period**, including any time for treatment and recovery? YES ☐ NO ☐
   If yes, estimate the dates of incapacity that the employee is UNABLE to work. (*Please do not state unknown or indeterminate.*)

   Beginning Date: _____/_____/_____ through End Date _____/_____/_____ (*the end date is not the same as the return-to-work date*)

6. **REDUCED WORK SCHEDULE Leave**

   Estimate the **part-time hours** or **reduced work schedule** the employee needs, if any (*but NOT included in question #7*):

   May work: _____ hour(s) per day; _____days per week from: Beginning Date: _____/_____/_____ through End Date _____/_____/_____

   Please explain medical necessity:_____

7. **INTERMITTENT Leave**

   Due to the patient's medical condition, is it medically necessary for them to be absent from work on an **intermittent basis** (periodically) such as for appointments or episodes of incapacity? YES ☐ NO ☐ (If yes, provide your ***best estimate*** of how often and how long the absences will last.)

   A. Planned Absences Includes scheduled or expected follow-up appointments and medical treatments.

   Appointment Frequency:

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

   Appointment/Recovery Duration:

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

   B. Unplanned Absences: Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-up episodes and the duration of related incapacity that the patient may have over the next 6 months.

   Episode Frequency:

   May occur up to _____times (*select one*) ☐ every _____week(s) ***OR*** ☐ every _____ month(s)
   number *number* *number*

   Episode Duration:

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

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

_____

_____

_____

_____

Signature of Health Care Provider_____ ***Date:*** _____/_____/_____