

**CERTIFICATION OF HEALTHCARE PROVIDER  
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION  
EXTENDED MEDICAL LEAVE & FAMILY MEDICAL LEAVE ACT FORM**

**SECTION I: For Completion by the EMPLOYEE:** Please complete Section I before giving this form to your medical provider. The University Extended Medical Leave Policy and FMLA permits Florida Atlantic University (FAU) to require that you submit a timely, complete, and sufficient medical certification to support a request for Extended Medical and/or FMLA leave due to your own serious health condition. Failure to provide a complete and sufficient medical certification may result in a denial of your Extended Medical Leave and/or FMLA request. You have up to 15 calendar days to return this form.

Employee Name: \_\_\_\_\_

Employee Department and Job Title: \_\_\_\_\_

Supervisor Name and Phone Number: \_\_\_\_\_

Regular Work Schedule: \_\_\_\_\_

Employee's Essential Job Functions: \_\_\_\_\_

Anticipated length of Parental Leave: \_\_\_\_\_

Previous Employment with FAU?  Yes  No If yes, dates: \_\_\_\_\_

**SECTION II: For Completion by the HEALTH CARE PROVIDER:** Your patient has requested leave under the University Extended Medical Leave Policy and/or FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon 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 Extended Medical Leave and/or FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. **Please be sure to sign the form on page 3 and page 4 if additional information is provided.**

Provider Name and Business Address: \_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_

**Please return the completed form to the patient or directly to:  
Florida Atlantic University  
Human Resources Department  
777 Glades Road, Boca Raton, FL 33431  
Attn: Michael O'Hern  
Confidential Fax: (561) 297-4220**

**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? \_\_\_ No \_\_\_ Yes. If so, dates of admission:

\_\_\_\_\_

Date(s) you treated the patient for the condition:

\_\_\_\_\_

Will the patient need to have treatment visits at least twice per year due to the condition?

\_\_\_ No \_\_\_ Yes

Was medication, other than over the counter medication, prescribed? \_\_\_ No \_\_\_ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapy)? \_\_\_ No \_\_\_ Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2. Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employee in Section I to answer this question based upon their description of his/her job functions.

Is the employee **unable** to perform any of his/her job functions due to the condition: \_\_\_ No \_\_\_ Yes

If so, identify the job functions the employee is **unable** to perform:

\_\_\_\_\_

4. Describe 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**

5. 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? \_\_\_ No \_\_\_ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee’s medical condition? \_\_\_ No \_\_\_ Yes

If so, are the treatments or the reduced number of hours of work medically necessary?  
\_\_\_ No \_\_\_ Yes

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 or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hours(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? \_\_\_ No \_\_\_ Yes.

Is it medically necessary for the employee to be absent from work during the flare ups?  
\_\_\_ No \_\_\_ Yes. If so, 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: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**

