FLORIDA ATLANTIC UNIVERSITY

CERTIFICATION OF HEALTHCARE PROVIDER
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION/PARENTAL LEAVE
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: _____Z#_____

Preferred Method of Contact: Email_____ Cell/Home Phone_____

Employee Department and Job Title: _____

Supervisor Name: _____ Dean/Director Name: _____

Timekeeper Name and Phone Number: _____

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.**

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, Department of Human Resources
777 Glades Road, IS4
Boca Raton, FL 33431-0991
Attn: Kavon Nikfar
Phone (561) 297-0319 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?

   Yes____ No____ If yes, 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? 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 therapy)?

   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 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

Use the information provided by the employee on Page 1 Section 1 to answer this question based upon the description of his/her job functions.

4. 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 ending dates for the period of incapacity:

   _____

5. **During this incapacity, is it necessary for the employee to be absent from work for a continuous period of time?**

   Yes____ No____ If yes, estimated date of continuous absence:

   _____

6. **During this period of incapacity**, is the employee **unable** to perform any of his/her job functions due to the condition?

   Yes____ No____ If yes, identify the job functions the employee is **unable** to perform:_____

   _____

7. **During this period of incapacity,** is it medically necessary to attend follow-up treatment appointments?

   Yes____ No____

   If yes, estimate treatment schedule, including dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

8. **During this period of incapacity,** will the employee need to work part-time or on a reduced schedule because of the employee's medical condition?

   Yes____ No____ If yes, estimate the part-time or reduced work schedule the employee needs:

   _____ hour(s) per day; _____days per week from _____ through_____

9. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? Yes____ No____

   Is it medically necessary for the employee to be absent from work during the 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: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:
Attach supplementary sheet if necessary

_____

_____

_____

Signature of Health Care Provider **Date**

Return to:
Florida Atlantic University · Human Resources · 777 Glades Road, Boca Raton, FL 33431
Attn: Kavon Nikfar · Confidential Fax: (561) 297-4220