FLORIDA ATLANTIC UNIVERSITY

CERTIFICATION OF HEALTHCARE PROVIDER
FOR <u>FAMILY MEMBER'S</u> 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 family member or his/her 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 to care for a covered family member with a 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. FAU must give you up to 15 calendar days to return this form.

Employee Name: _____Z#_____

Employee Department and Job Title: _____

Supervisor Name: _____ Dean/Director Name: _____

Timekeeper Name and Phone Number: _____

Previous Employment with FAU? Yes____ No____ If yes, dates: _____

Name of family member for whom you will provide care _____
First Middle Last

Relationship of family member to you: _____

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

Describe care you will provide to your family member and <u>estimate leave needed</u> to provide care:

_____

_____

_____

_____ _____

Employee Signature **Date**

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: Robin Kabat • Confidential Fax: (561) 297-4220

SECTION II: For Completion by the HEALTH CARE PROVIDER: The employee listed above has requested leave under the University Extended Medical Leave Policy and/or FMLA to care for your patient. 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 patient needs leave. Page 4 provides for space for additional information, should you need it. **Please be sure to sign the form on the last page.**

Provider Name and Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

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 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 NEEDED: When answering these questions keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygiene, nutritional, safety, or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? Yes____ No____ If yes, estimate the beginning and ending dates for the period of incapacity:

   _____

   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, estimate treatment schedule, including 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 schedule basis, including any time for recovery?

   Yes____ No____ If yes, estimate the hours the patient needs care on an intermittent basis:

   _____ hours(s) per day; _____ days per week from _____ through_____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? Yes____ No____

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

Does the patient need care during these flare-ups? Yes____ No____

Explain the care needed by the patient, and why such care is medically necessary:

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

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