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#_____

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:

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

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**

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

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