THE UNIVERSITY OF MEMPHIS

Family and Medical Leave Act
Certification of Health Care Provider for
Employee's Serious Health Condition

Human Resources, 165 Administration Building, (901) 678-3573 FAX (901) 678-1650

EMPLOYEE AUTHORIZATION

I authorize a representative of UofM's Human Resources Department to communicate directly with my health care provider for confirmation of the medical condition described in Part B of this form and clarification regarding my need for an alternative work arrangement.

Employee Signature:_____ Date: _____

Section I: Employer

Date:_____ Employer name/contact: University of Memphis, Dept. of Human Resources, 165 Administration Building, 38152

Name:_____ Phone:_____ Fax:_____ E-Mail:_____

Section II: Employee

Date: _____

Employee's name: _____

First Middle Last

Employee's job title:_____ Regular work schedule: _____

Job description is attached and further job details can be obtained from the employee.

Section III: Health Care Provider

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the 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 FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. **Failure to provide a complete and sufficient medical certification within 15 calendar days of the date above may result in a denial of your patient's FMLA request.**

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential care facility? Yes ☐ No ☐

   If yes , 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:

Employee's name: _____

2. Is the medical condition pregnancy? Yes ☐ No ☐

   If yes, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   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:

4. Describe other relevant medical facts, if any, 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? Yes ☐ No ☐

   If yes, 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? Yes ☐ No ☐

   If yes, are the treatments or the reduced number of hours of work medically necessary? Yes ☐ No ☐

   Estimate treatment schedule, if any, including the 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:

   _____ hour(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?

   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

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Employee's name: _____

ADDITIONAL INFORMATION (Identify question number with your additional answer):

Anticipated return to work date: _____
(required information)

Signature of Health Care Provider _____ **Date** _____