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

Section I: Employer

Date:_____

Employer name and contact:

University of Memphis
Department of Human Resources
165 Administration Building
Memphis, TN 38152

Name _____

Phone _____

Fax_____

E-mail _____

Section II: Employee

Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification within _____ calendar days of the date above may result in a denial of your FMLA request.

Your name: _____
First Middle Last

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 estimate leave needed to provide care:

Employee Signature _____ Date _____

Section III: Health Care Provider

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 3 provides space for additional information, should you need it.

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 medical care facility? Yes ____ No ____

   If yes, date(s) of admission: _____

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Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
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Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? Yes ____ No ____

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

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

   If yes, expected delivery date: _____

3. Describe other relevant medical facts, if any, 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, hygienic, 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 ____

   Estimate the beginning and ending dates for the period of incapacity: _____

5. During this time, will the patient need care? Yes ____ No ____

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

6. Will the patient require follow-up treatments, including any time for recovery? 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:

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Your name: _____
First Middle Last

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

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

7. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
Yes ____ No ____

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____.

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

8. 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):

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