Family Medical Leave
Certification of Health Care Provider for Employee’s Serious Health Condition

Employee’s Name: ________________________________________
First  Middle  Last

Instructions to the Health Care Provider: Your patient has requested leave under the Family Medical Leave Act (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. Please be sure to sign this form on the last page.

Provider’s Name and Business Address: ______________________________________________________________________

Type of Practice/Medical Specialty: ______________________________________________________________________

Telephone: ( ) ___________________________ Fax: ( ) ___________________________

Part A: Medical Facts
1. Diagnosis (describe relevant medical facts such as symptoms, diagnosis, or any regimen of continuing treatment):
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Approximate date condition commenced: ___________________________

Probable duration of condition: ___________________________

Probable duration of the patient’s present incapacity (if different): ___________________________

Was 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 condition: ___________________________

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
___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. After discussing with the employee his/her essential job functions and job description:

Is the employee able to perform work of any kind (if no, skip the next question)? ___No  ___Yes

Is the employee able to perform the functions of his/her position? ___No  ___Yes
Part B: Amount of Leave Needed

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? ___No ___Yes, if so, estimate the beginning and ending dates for the period of incapacity:

________________________________________________________________________________________

5. 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 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_____________.

6. 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

7. The following statement(s) apply to the employee as a result of the condition(s) listed in item 1:

The employee may return to work on __________________ (date) with no restrictions.

The employee may return to his/her regular position with the following restrictions (based on the employer’s statement of essential functions of the employee’s position, or if none provided, after discussing with the employee): _______________

________________________________________________________________________________________

_________until________________________ (probable date of return to normal job duties, if applicable).

The employee may not return to work until further evaluation on ______________ (date of next appt.).

________________________________________________________________________________________

Signature of Health Care Provider ____________________________________________________________________ Date ________________________________

Return Completed Form to: Lamar University/Lamar Institute of Technology Human Resources Office
PO Box 11127 Beaumont, TX  77710 or Fax to (409) 880-8464