FAMILY MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER for Employee's Serious Health Condition

SECTION I – For completion by the EMPLOYER	
Employer Contact: Division of Human Resources, Leave Coordinator	Phone: 305-348-2181/305-348-6462
Regular Work Schedule: See Attached Position Description	
Employee's Essential Job Functions: See Attached Position Description	

SECTION II – For completion by the EMPLOYEE	
Employee Name:	Employee ID No.:
Position Title:	Campus Phone:
Supervisor's Name:	Supervisor's Phone:
Current Mailing Address:	
Home Phone Number :	Cell Number:
FIU email address:	Alternative email:

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. §825.305(b).

SECTION III – For completion by the 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

PLEASE BE SURE TO SIGN THE FORM ON THE LAST PAGE.

Name of Health Care Provider (please use Medical Stamp):	Type of Practice / Medical Specialty:
Address:	Telephone Number / Fax Number:

PART A – MEDICAL FACTS

1. Approximate date condition commenced :	2. Probable duration of condition:
3. Was or will the patient be admitted for an overnight stay in a hospital, hospice, or residential medical facility? ❒ NO ❒ YES If **YES**, date of admission:	4. Date(s) you treated the patient for condition: 5. Will the patient need to have treatment visits at least twice a year due to condition? ❒ NO ❒ YES

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Employee Name:

6. Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

7. Was the patient referred to other health care provider(s) for evaluation or treatment(s) (e.g., physical therapist)?

❒ NO ❒ YES If **YES**, state the nature of such treatments and expected duration of treatment(s):

8. Is the medical condition pregnancy?

❒ NO ❒ YES If **YES**, expected delivery date:

9. 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.

a. Is the employee **unable** to perform any of his/her job "essential" functions due to the condition? ❒ NO ❒ YES
b. If **YES**, identify the "essential" job functions the employee is unable to perform:

10. Describe other 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). Please make writing legible.

PART B – AMOUNT OF LEAVE NEEDED

11. 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

a. If **YES**, please provide your best estimate of the beginning and ending dates for the period of incapacity:

Start Date _____ Ending Date _____

12. 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 _____

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Employee Name:

13. 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 RESPONSE:

_____ _____

Signature of Health Care Provider **Date**

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