FIU FLORIDA INTERNATIONAL UNIVERSITY
Division of Human Resources

CERTIFICATION OF HEALTH CARE PROVIDER for Family Member's Serious Health Condition

Family SECTION I – For completion by the EMPLOYER	
Employer Contact: Benefits Leave Administrator , Division of Human Resources, Benefits	Phone: 305-348-2079 / 305-348-6462

SECTION II – For completion by the EMPLOYEE

INSTRUCTIONS to the 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. 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 to your employer. 29 C.F.R. § 825.305.

Employee Name:	Employee ID No.:
Employee Position Title:	Campus Phone:
Supervisor's Name:	Supervisor's Phone:
Current Mailing Address:	
Home Phone Number :	Cell Number:
FIU email:	Alternative email:

Name of Family Member for whom you will provide care:

First Name ______________________________ Middle Initial _____ Last Name ______________________________

Relationship of family member to you:

❒ Spouse ❒Son/Daughter – Date of Birth _________________ ❒ Parent ❒ Sibling

Describe care you will provide to your family member and estimate leave needed to provide care:

a. Estimate Leave needed: ____

b. Describe care you will provide:

____ _______________________________________

Employee's Signature Date

SECTION III – For completion by the 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it.

PLEASE BE SURE TO SIGN THE FORM ON THE LAST PAGE

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SECTION III – For completion by the HEALTH CARE PROVIDER (continued)

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. Will the patient need to have treatment visits at least twice a year due to condition?

   ❒ NO ❒ YES
5. Dates you treated the patient for condition:
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 (e.g., physical therapist)?

   ❒ NO ❒ YES If **YES**, state the nature of such treatments and expected duration of treatment:
8. Is the medical condition pregnancy?

   ❒ NO ❒ YES If **YES**, expected delivery date:
9. 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 CARE NEEDED

10. Will the patient 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 ________________

    b. During this time, will the patient need care? ❒ NO ❒ YES
    c. If **YES**, explain the care needed by the patient and why such care is medically necessary:

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

❒ NO ❒ YES

a. If **YES**, estimate treatment schedule, including the dates of any scheduled appointments and time required for each appointment, including any recovery period:

b. **AND** explain the care needed by the patient, and why such care is medically necessary:

12. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

❒ NO ❒ YES

a. If **YES**, estimate the hours the patient needs care on an intermittent basis,:

_________ hour(s) per day; ________ days per week from ______________ through _______________

b. **AND** explain the care needed by the patient, and why such care is medically necessary:

13. Will the condition cause episodic flare-up periodically preventing the patient from participating in normal daily activities?

❒ NO ❒ YES

a. If **YES**, 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:

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

b. **AND** explain the care needed by the patient, and why such care is medically necessary:

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL RESPONSE:

_______________________________________ _______________________________________

Signature of Health Care Provider **Date**

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