

The University of Memphis

Certification of Health Care Provider Family and Medical Leave Act of 1993

The information sought on this form relates only to the condition for which the employee is taking Family and Medical leave Act (FMLA) leave. "Incapacity" for purposes of FMLA is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

Employee's Name _____

Patient's Name _____

1. Does this patient's condition qualify under any of the categories described under the FMLA (see appendix for complete description)? If so, please check the applicable category.
 1. Hospital Care
 2. Absence plus treatment
 3. Pregnancy
 4. Chronic conditions
 5. Permanent/long-term conditions
 6. Multiple treatments (non-chronic conditions)
 7. None listed
2. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:
3. State the approximate date the condition commenced, the probable duration of the condition, and if different, the probable duration of the patient's present incapacity.
 - a. Will it be necessary for the employee to *work only intermittently or to work on a less than full schedule* as a result of the condition? If yes, give the probable duration:
 - b. If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:
4. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:
 - a. If the patient will be absent from work because of treatment on an intermittent or part-time basis, provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment, if known, and period required for recovery if any:
 - b. If any of these treatments will be provided by another provider of health services (e.g. physical therapist), please state the nature of treatments:
 - c. If a regimen of continuing treatment is required, provide a general description of such regimen (e.g. prescription drugs, physical therapy requiring special equipment):
5. If medical leave is required for the **employee's own serious health condition** including absences due to pregnancy or a chronic condition,

- a. Is the employee unable to perform work of any kind?

- b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? Employee or employer should supply you with information about the essential functions. If yes, please list the essential functions the employee is unable to perform:

- c. If neither a nor b applies, is it necessary for the employee to be absent from work for treatment?

- 6. If leave is required to care for a **family member of the employee** with a serious health condition,
 - a. Does the patient require assistance for basic medical or personal needs or safety, or for transportation?

 - b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist the patient's recovery?

 - c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

Approximate date employee will be able to return to work: _____

List any restrictions: _____

Health care provider name (please print): _____

Type of practice: _____ Phone number: _____

Address: _____

Signature of health care provider

Date

To be completed by the employee needing family leave to care for a family member.

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

Employee Signature

Date