**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**