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Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Wage and Hour Division

Do not send completed form to the Department of Labor; Return to the Patient.

OMB Control Number: 1235-0003 Expires: 8/31/2021

Section I: Instructions to the Employee:

Please complete Section I 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. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Please submit this form within 15 calendar days of receiving it.

Your Name_____

First **Middle** **Last**

Medical Authorization

I,_____, do hereby authorize my health care provider to furnish to The University of Tulsa (hereinafter "TU") all relevant medical records, reports, medical charts, laboratory records and reports, x-rays and x-ray readings and reports, and any and all records pertaining to my medical case, history, condition, treatment, diagnosis or expenses, including my psychological status to the extent any such information has a bearing on my ability to perform the responsibilities and expectations of the essential functions of my position as a_____(title) at TU. The purpose of the requested disclosure is for FMLA leave time.

I also authorize TU, any of its employees, representatives, and agents, to release information to my health care provider as needed to support my request for FMLA leave time, including records and statements, regarding relevant background information giving rise to the request for reasonable accommodation and/or medical leave related to this medical authorization.

I acknowledge that the law of the State of Oklahoma provides that the information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune DeficiencySyndrome ("AIDS") and/or mental health information.

I also acknowledge that the persons or entities authorized to receive the information above are not a health care provider, that the information is being disclosed to a third party and that the information may no longer be protected by federal or state laws that are currently in effect, particularly the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that I may revoke this authorization at any time by submitting a written request to Campus Accessibility Services. A facsimile or photocopy of this form will have the same force and effect as the original signed copy.

_____
Print Name of Employee

_____ _____
Signature of Employee Date

Printed Name of Employee: _____

Section II: 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.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

Please attach a copy of your business card.

Part A – Medical Facts:

1) Approximate date condition commenced/will commence: _____

2) Probable duration of condition: _____

3) Does the patient's condition qualify as a "serious health condition" under FMLA? _____Yes _____No

4) Please see the definitions of these serious health conditions on the last page, check any of the following applicable serious health conditions, and answer the questions about estimated duration:

☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

_____

☐ **Incapacity plus Treatment:** *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ expected to be) incapacitated for *more than three* consecutive, full calendar days from _____(mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions:** *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long-Term Conditions:** *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it

is medically necessary for the patient to receive multiple treatments.

☐ **None of the above:** If none of the above condition(s) were checked, no additional information is needed. Go to page 4 to sign and date the form.

5) Use the information provided by the employee in Section I to answer this question. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).
Is the employee unable to perform any of their job functions due to the condition? ____ Yes ____No
If so, identify the job functions the employee is unable to perform (here or identify on the job description):

_____

_____

_____

6) Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (medical facts may include symptoms, diagnoses, or any regimen of continuing treatment such as the use of specialized equipment)._____

_____

_____

Part B: Amount of Leave Needed

7) Due to the condition, the patient (☐ had /☐ will have**) planned medical treatment(s) (scheduled medical visits)** *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

8) Due to the condition, the patient (☐ was /☐ will be) **referred to other health care provider(s) for evaluation or treatment(s)**. State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

_____

Provide your **best estimate** of the beginning date_____*(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

9) Due to the condition, it is **medically necessary for the employee to work a reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to_____*(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

10) Due to the condition, the patient (☐ was /☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date_____*(mm/dd/yyyy)* and end date_____ *(mm/dd/yyyy)* for the period of incapacity.

Printed Name of Employee: _____

11) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from **work on an intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups.Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours/ ☐ days) per episode.

(10) Please attach any **additional information** as relevant.

_____
Printed Name of Health Care Provider

_____ _____
Signature of Health Care Provider Date (mm/dd/yyyy)

Printed Name of Employee: _____

Serious Health Conditions

Family and Medical Leave Act of 1993 Definitions (See 29 C.F.R. §§ 825.113-.115)

1. Inpatient Care

An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Incapacity Plus Treatment

A period of incapacity of more than three consecutive, full calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves either:

a) Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or

b) At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

3. Pregnancy

Any period of incapacity due to pregnancy or for prenatal care**.**

4. Chronic Conditions

Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

6. Conditions Requiring Multiple Treatments (Non-Chronic Conditions)

Restorative surgery after an accident or other injury; or a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

Updated November 2020