FLORIDA STATE COLLEGE AT JACKSONVILLE

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

SECTION I

Employer name: Florida State College at Jacksonville

Employer contact: Benefits Office

Telephone: (904) 632-3018 Confidential Fax: (904) 632-3329

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Employee name: _____ EMPLID: _____
First Middle Last

Employee Title: _____

Work Schedule: _____

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. Please be sure to sign the form on the last page.

Provider's name: _____
(Please Print)

Provider's business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the 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 medication, other than over-the-counter medication, prescribed?____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. Based upon the employee's own description of his/her job functions, is the employee unable to perform any of his/her job functions due to the condition:_____No_____Yes

If so, identify the job functions the employee is unable to perform: _____

_____

_____

4. Describe other relevant medical facts, if any, 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): _____

_____

_____

_____

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. 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: _____

_____

6. 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_____

7. 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 ANSWER.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**