FLORIDA STATE COLLEGE AT JACKSONVILLE

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

SECTION I

Employer name: Florida State College at Jacksonville

Employer contact: Benefits Office

Telephone: (904) 632-3167 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 family member or his/her 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. The schedule listed in Section II below must mirror exactly the schedule in PeopleSoft or the request will be denied.

Employee name: _____ EMPLID: _____
First Middle Last

Employee Title: _____

Work Schedule: _____

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: ☐ Spouse ☐ Parent ☐ Child
Please Note: Proof of relationship status may be requested.

If family member is your son or daughter, date of birth: _____

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

_____

_____

_____

_____

_____ _____
Employee 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 patient's condition for which the employee needs leave.** Page 4 provides space for additional information, should you need it. 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: _____

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: _____

Was medication, other than over-the-counter medication, prescribed?____No____Yes

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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED:

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? _No___Yes

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care?___No___Yes

Explain the care needed by the patient and why such care is medically necessary:

_____

_____

_____

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

_____

_____

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

Estimate the hours the patient needs care on an intermittent basis, if any:

_____hour(s) per day;_____days per week from_____through _____

Explain the care needed by the patient, and why such care is medically necessary:_____

_____

_____

_____

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?____No____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 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

Does the patient need care during these flare-ups?_____No_____Yes

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION:

IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider **Date**