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):

____________________________

____________________________

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____________________________


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.

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

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________________________________________________________________________________

Signature of Health Care Provider ___________________________ Date __________

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