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) 632-3018 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 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.

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 ___________________________

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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):

________________________________________________________________________

________________________________________________________________________

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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:

____________________________________________________________________________________

____________________________________________________________________________________

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

____________________________________________________________________________________

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: ____________________________

______________________________

______________________________

______________________________

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ADDITIONAL INFORMATION:
IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Signature of Health Care Provider ____________________________ Date ____________________________

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