FMLA: Certification of Health Care Provider for Serious Health Condition - Vincennes University

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider.

Employee should complete this section prior to giving this form to your medical provider. The FMLA permits an employer to require that you should submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, 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. Your employer may give you at least 15 days to return this form.

Employee Name: ID #:

Job Title: Department:

The request for leave is for my own serious health condition.

The request for FMLA leave is for the care of a family member with a serious health condition. Please provide the following:

Name of family member for which you will be providing care: Relationship of family member to you:

If family member is a son/daughter, date of birth:

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

Employee Signature: **Date:**

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, genetic services, or the manifestation of disease or disorder in the employee's family members. **Please be sure to sign the completed form.**

Provider's Name: Contact #

Business Address:

Medical Specialty: FAX #

Medical Facts:

Date condition commenced: Probable Duration:

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes Dates of Admission:

Date (s) you treated the patient for the condition:

Is the serious health condition a pregnancy?

No Yes Expected Delivery Date

Is the employee able to perform any of his/her job functions due to the condition:

No Yes

If Yes, please list restrictions:

Describe other relevant facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regiment of continuing treatment such as the use of specialized equipment):

Amount of Care Needed:

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:

to

During this time, will the patient need care?

No Yes

Will patient require follow-up treatments, including time for recovery?

No Yes

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

Signature of Health Care Provider: **Date:**

The completed, signed form should be returned to the Vincennes University Human Resources by mail:
1002 North First Street, Vincennes, IN 47591;
by scan/email: rmccord-fithian@vinu.edu;
or by FAX : 1.812.888.5055.
Questions? Please contact VU Human Resources at 1.812.888.6947.