



University of Central Florida, Human Resources, 12201 Research Pkwy #200, Orlando, FL 32826
Phone: 407-823-2771 – Confidential Fax: 407-882-9023

THE COMPLETED FORM MUST BE FORWARDED DIRECTLY TO UCF HUMAN RESOURCES.

SECTION I – EMPLOYEE COMPLETES

Please complete and sign Section I before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days. 29 C.F.R. § 825.305. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

Your name: Last First Middle

Patient name: Last First Middle

Relationship to you: If child, date of birth: Dates requested for leave: TO

Briefly describe the care you will provide to your family member: Assist with basic medical, hygienic, nutritional, or safety needs Transportation Physical Care Psychological Comfort Other:

Give your best estimate of the amount of time away from work needed to provide the care described:

UCF ID Employee Signature Date

Purpose and Use Statement: The University must generally maintain records and documents relating to medical certifications, recertification, or medical histories of employees, created for FMLA purposes, as confidential medical records in separate files/records from the usual personnel files, with an FMLA Administrator.

SECTION II – HEALTH CARE PROVIDER COMPLETES

The employee listed above has requested medical leave under FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. Please provide your contact information, state license number, and complete all relevant parts of this Section. Your answers should be your best estimate based on 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. Note: Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the next page.

Provider's name and business address:

Type of practice/Medical specialty: State License Number:

Telephone: Fax:

PART A: Medical Facts Please provide complete information for the determination of eligibility for leave under FMLA and UCF policy.

1. Approximate date condition commenced or will commence:

Provide your best estimate of how long the condition lasted or will last:

For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? YES NO

If so, date(s) 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? YES NO

Was medication, other than over-the-counter medication, prescribed? YES NO

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? YES NO

If yes, state the nature of such treatments and expected duration of treatment:

UCF Certification of Healthcare Provider Form for a **Family Member's** Serious Health Condition under the Family and Medical Leave Act

2. **Is the medical condition pregnancy?** YES NO If yes, expected delivery date: ____/____/____

3. **Describe diagnosis and other relevant medical facts related to the patient's 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 Please be specific on the amount of time and/or dates. Keep in mind your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical or psychological care.

4. **CONTINUOUS INCAPACITY**

Will the patient be incapacitated for a **single continuous period** including any time for treatment(s) and/or recovery? YES NO

If yes, estimate the beginning and end dates for the period of patient incapacity. (Please do not state unknown or indeterminate.)

Beginning Date: ____/____/____ through End Date ____/____/____

5. **INTERMITTENT INCAPACITY OR CARE**

Due to the patient's medical condition, is it medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically) such as for appointments or any episodes of incapacity such as episodic flare-ups? YES NO

If yes, provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last below.

A. Planned Absences: Includes scheduled or expected follow-up appointments and medical treatments.

Appointment Frequency:

Up to ____ time(s) (select one) every ____ week(s) **OR** every ____ month(s) **OR** each year.
number number number

Appointment/Recovery Duration:

Each may last up to (select one) ____ hour(s) **OR** ____ day(s)
number number

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

B. Unplanned Absences: (such as flare-ups which would require the employee to care for the patient)

Episode Frequency:

May occur up to ____ times (select one) every ____ week(s) **OR** every ____ month(s)
number number number

Episode Duration:

Each episode may last (select one) ____ hour(s) **OR** ____ day(s)
number number

Please explain the care the patient will need during each flare-up, and why such care is medically necessary: _____

Additional Information: Identify Question Number with Your Additional Answer (attach separate sheet if necessary):

Signature of Health Care Provider _____ Date: ____/____/____