



Human Resources
 A6200 UCA, 282 Champions Way
 Tallahassee, FL 32306-2410
 Phone: 850-644-5051
 Fax: 850-645-9512

Family and Medical Leave/Parental Leave Health Care Provider Certification Form

A complete medical certification is required to determine whether the employee's serious health condition, or the serious health condition of the employee's spouse, child, or parent, qualifies under the FMLA. Please return this form to the FMLA Administrator in Human Resources (not the employee's department):

Address: Florida State University
 A6200 University Center
 282 Champions Way
 P.O. Box 3062410
 Tallahassee, FL 32306-2410

OR

**Fax: 850-645-9512
 Internal FSU Mail Code: 2410**

Employee's Name: _____

Patient's Name (if not the employee): _____

Patient's Relationship to the employee: Self Spouse Child Parent

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.

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?

YES NO If yes, 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? 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 and expected duration of the treatment:

2. Is the patient's medical condition pregnancy? YES NO

If yes, expected delivery date: _____

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

4. If the employee is the patient, is the employee unable to perform any one or more of the essential functions of the employee's job? (The employee or employer should supply you with information about the essential job functions). YES NO

If yes, please list the essential functions the employee is unable to perform.

Part B: Amount of Leave Needed

5. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? YES NO

If yes, estimate the beginning and ending dates for the period of incapacity: _____

Duration: _____ through _____

6. Will the patient need to attend follow-up treatment appointments? YES NO

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment:

If the employee is the patient, provide an estimated part-time or reduced work schedule for the employee:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities or prevent an employee from performing his/her job functions? YES NO

Is it medically necessary for the employee to be absent from work during the flare-ups? YES NO

Is yes, 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

8. If leave is required for a family member's serious health condition, please explain the care needed by the patient and why such care is medically necessary:

Health Care Provider's Name (print)

Signature of Health Care Provider

Type of Practice

Address of Health Care Provider

Telephone Number

Fax Number

Date