



Alabama Agricultural and Mechanical University
Office of Human Resources

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CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION
(Family and Medical Leave Act of 1993)

Date: _____

Section I: For completion by the Employer.

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions:

Check if job description is attached: _____

Section II: For completion by the Employee.

Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you 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 must give you at least fifteen (15) calendar days to return this form.

Employee's name: _____
First Middle Last

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 page 4.

Provider's name and business address: _____

Type of practice/medical specialty: _____

Telephone: () _____ Fax: () _____

Part A: Medical Facts

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).

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. Use the information provided by Alabama A&M University in Section I to answer this question. If Alabama A&M University fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Can the employee perform any of his/her job functions due to the condition: _____ No _____ Yes.

If not, 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 as 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

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:
