University of Missouri
Certification of Health Care Provider for Employee's Serious Health Condition
(Family and Medical Leave Act)

SECTION I: For Completion by EMPLOYER

Employer Name	Employer Contact Information
Employee's Job Title	Employee's Regular Work Schedule
Employee's Essential Job Functions	Check if job description is attached ☐

SECTION II: For Completion by 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. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee's Name (First, Middle, Last)	Employee's EmplID

SECTION III: For Completion by 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 the last page.**

Provider's Name	Provider's Business Address
Type of Practice/Medical Specialty	
Telephone ( )	Fax ( )

Part A: MEDICAL FACTS

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? ☐ Yes ☐ No	If yes, 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 treatment and expected duration of treatment:	

2. Is the medical condition pregnancy? ☐ Yes ☐ No | If yes, expected delivery date

3. Use the information provided by the employer in Section I to answer this question. If the employer 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.

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

If yes, 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 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 or recovery? ☐ Yes ☐ No

If yes, 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? ☐ Yes ☐ No

If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

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? ☐ Yes ☐ No

Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

If 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., I episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) month(s) _____ Duration: _____ hour(s) or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

_____ _____

Signature of Health Care Provider Date