CERTIFICATION OF HEALTH CARE PROVIDER – SHARED LEAVE PROGRAM FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

NOTE: IF APPLYING FOR FMLA OR MEDICAL LEAVE, ADDITIONAL FORMS ARE REQUIRED

SECTION I: FOR COMPLETION BY EMPLOYER | UNIVERSITY OF MISSOURI HEALTH CARE

Employee's Name: Employee's ID Number:

Department:

Supervisor Name:

SECTION II: FOR COMPLETION BY LICENSED HEALTH CARE PROVIDER

Your patient has requested leave for a catastrophic event. **Please note that we are defining a catastrophic event as "a major illness, injury or medical condition which is life threatening, terminal or likely to result in a substantial permanent disability as certified in writing by a health provider"**. Based on the definition of catastrophic event, 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. 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 and Business Address:

Type of Practice / Medical Specialty:

Office Telephone:

Office Fax:

PART A | MEDICAL FACTS

1. Is this condition a catastrophic event defined as a major illness, injury or medical condition which is life threatening, terminal or likely to result in a substantial permanent disability? ☐Yes ☐No ____ Licensed Provider Initials

2. Approximate date condition commenced:

   Probable duration of condition:

3. 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

1. 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? ☐Yes ☐No

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

2. **ADDITIONAL INFORMATION |** Identify question number with your additional answer

Signature of Health Care Provider Date:

Printed Name of Health Care Provider and Degree Level (MD, DO, FNP, etc.)

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 an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do 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 reproduction services.