Pennsylvania's STATE SYSTEM of Higher Education

Family and Medical Leave Act
Employee Serious Health Condition Certification

SECTION 1: TO BE COMPLETED BY EMPLOYEE

INSTRUCTIONS to the EMPLOYEE:

- **PLEASE COMPLETE SECTION 1 BEFORE GIVING THIS FORM TO YOUR HEALTH CARE PROVIDER.** The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for an absence that may qualify as FMLA leave (Sick Leave Without Pay) due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA protections and Sick leave without pay. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA and sick leave without pay request. **You have 15 days to return this form.**
- **SECTION 2 OF THIS FORM MUST BE COMPLETED BY THE TREATING HEALTH CARE PROVIDER;** it is inappropriate for it to be completed by anyone other than that provider.
- Note: If this is a request for leave for a family member or next of kin, you cannot use this form. Please obtain either: *Family Member Serious Health Condition Certification* OR *Serious Injury or Illness of a Covered Servicemember Certification* from your Human Resource Office.

Employee Name	Personnel Number	Is this condition the result of a work-related injury? ☐ No ☐ Yes
University		Work Location

SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER:

- **INSTRUCTIONS to the HEALTH CARE PROVIDER: PLEASE BE SURE TO SIGN THE LAST PAGE.**
- The employee listed above 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 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 response to the condition for which the employee is seeking leave.

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 not provide any genetic information when responding to this request for medical information. None of the questions on this form require genetic information.

Supporting Medical Certification:

1. Approximate date condition commenced	2. Probable duration of condition (be as specific as you can)
3. Approximate date **incapacity*** commenced	4. Date(s) you treated patient for condition

5. Was patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
☐ No ☐ Yes If yes, please list most recent date of admission _____ and discharge _____

6. Will the patient need to have treatment visits at least twice per year due to the condition?
☐ No ☐ Yes

7. Was medication, other than over-the-counter medication, prescribed?
☐ No ☐ Yes

8. Was the patient referred to another health care provider(s) for evaluation or treatment (example: physical therapist)?
☐ No ☐ Yes If yes, state the nature of such treatments and expected duration of treatment.

9. Is the medical condition pregnancy?
☐ No ☐ Yes If yes, expected delivery date is _____.

*Incapacity is the inability to work, attend school or perform other regular daily activities.

10. Using the attached job description or essential functions as a guide, is patient able to perform all of his/her job functions?

☐ No ☐ Yes If no, which functions cannot be performed due to this condition?

Medical Facts:

11. Describe 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).

Amount of Leave Needed

12. **Full-time Absence -** Was or will employee be incapacitated for a single continuous period of time due to the medical condition, including any time for treatment and recovery?

☐ No ☐ Yes If yes, specify the **begin date** _____ and **end date** _____ of the period of incapacity.

13. **Absences for Appointments -** Did or will employee need to attend follow-up treatment appointments because of the medical condition?

☐ No ☐ Yes If yes, estimate the appointment schedule, if any. Include the dates of scheduled appointments and the time required for each appointment, including any recovery period.

_____

Can appointments be scheduled during non-work hours?

☐ No ☐ Yes

14. **Absences for Flare-Ups (not part-time absences).** Will condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

☐ No ☐ Yes

If yes, is it medically necessary for employee to be absent from work during the flare-ups?

☐ No ☐ Yes If yes, please 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 patient may have over the next 6 months. (**Example:** 1 episode every 3 months lasting 1-2 days in duration).

Frequency: Number of times _____ per week; or Number of times _____ per month

Duration: Number of hours _____ per episode; or Number of days _____ per episode

15. **Part-Time Absences (not flare-ups).** Did or will employee need to work part-time or on a reduced schedule because of the employee's medical condition?

☐ No ☐ Yes If yes, estimate the part-time schedule the employee needs, if any.

Schedule of _____ Hours per day AND _____ Days per week from

begin date _____ to end date _____

By providing my signature, the undersigned health care provider certifies that the information is true and accurate.

Printed Name of Health Care Provider	Type of Practice/Medical Specialty	License Number
Address		Telephone Number
Name and Title of Staff Member (if form not completed by the Health Care Provider)		Fax Number
Signature of Health Care Provider		Date

Please return this form to the employee or to: **[NAME], SPF/FMLA Coordinator, [ADDRESS]**

Phone: Fax: Email: