Family and Medical Leave Act
Employee Serious Health Condition Certification

AFSCME & PSSU

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.

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<tr>
<th>Employee Name</th>
<th>Personnel Number</th>
<th>Is this condition the result of a work-related injury?</th>
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<td>☐ Yes ☐ No</td>
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University
California University of PA
Work Location

SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER:

INSTRUCTIONS to the HEALTH CARE PROVIDER:

- 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.
- Please be sure to sign the form on the last page.

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. What is the approximate date the condition commenced?

2. What is the probable duration of the condition?

3. When did the incapacity commence? (Incapacity is the inability to work or perform other regular daily activities.)

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

5. List date(s) you treated the patient for this condition.

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

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

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

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

10. Using the attached job description and essential functions as a guide, is the patient unable to perform any of the job functions due to the condition?  ☐ Yes  ☐ No  
    If yes, identify the job functions the employee is unable to perform.

**Medical Facts:**

11. 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).

**Amount of Leave Needed:**

12. Was or will the patient be incapacitated for a single continuous period of time due to the medical condition, including any time for treatment and recovery?  ☐ Yes  ☐ No  
   If yes, estimate the beginning and ending date for the period of incapacity.

13. Did or will patient need to attend follow-up treatment or evaluation appointments?  ☐ Yes  ☐ No  
   If yes, can treatments be scheduled during non-work hours?  ☐ Yes  ☐ No  
   If yes, are the treatments/appointments medically necessary?  ☐ Yes  ☐ No  
   If yes, estimate the treatment schedule, if any, including the dates of scheduled appointments and the time required for each appointment, including any recovery period.

14. Did or will the patient need to work part-time or on a reduced schedule because of the medical condition?  ☐ Yes  ☐ No  
   If yes, are the reduced number of work hours medically necessary?  ☐ Yes  ☐ No  
   If yes, estimate the part-time or reduced work schedule the employee needs, if any:

   Hours per day:  ______    Days per week:  ______
   List begin and end date of such schedule:

15. Will condition cause episodic flare-ups periodically preventing patient from performing job functions?  ☐ Yes  ☐ No  
   If yes, is it medically necessary for patient to be absent from work during the flare-ups?  ☐ Yes  ☐ No  
   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 duration of related incapacity that patient may have over the next six months,  
   (example: 1 episode every 3 months lasting 1-2 days).

   Frequency: Number of times per week or month:  _____  ☐ week or  ☐ month
   Duration: Number of hours or days per episode:  _____  ☐ hours or  ☐ days

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

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<th>Printed Name of Health Care Provider</th>
<th>Type of Practice/Medical Specialty</th>
<th>License Number</th>
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<th>Name and Title of Person Completing the form, if not the Health Care Provider</th>
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<th>Signature of Health Care Provider</th>
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Return completed form to the employee or return it directly mail or fax to:  
SPF Coordinator:  Debra Tidholm  408 Dixon Hall  California University of PA  250 University Ave.  California, PA 15419  
Phone: 724/938-5431   Fax:724/938-5740    Email: tidholm@calu.edu  
PASSHE 07/17/2012