THE UNIVERSITY OF ALABAMA IN HUNTSVILLE

Certification of Health Care Provider for Employee's Serious Health Condition
(For use when requesting a Medical Leave of Absence)

Please return completed form to Human Resources; SKH 102; 256.824.6908 (fax) or sara.elenbaas@uah.edu

Employee's Name: _____
Employee's Job Title: _____
Essential Job Functions: _____
_____

Note to Health Care Provider: Your patient has exhausted all available FMLA hours and has requested a medical leave of absence. Answer all applicable parts fully and completely. 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 Medical Leave of Absence coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, genetic services or the manifestation of disease or disorder in the employee's family members. 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: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ____No ____Yes. If so, dates of admission:

   _____

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2. 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:

_____

_____

3. Is the employee unable to perform any of his/her job functions due to the condition? ____No ____Yes. If so, 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 and recovery? ____No ____Yes

   If so, estimate the beginning and ending dates for the period of incapacity:

   _____

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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 _____ to _____

Part C: Additional Information: (Identify question number with your additional answer)

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**