SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

FMLA Medical Certification: Employee

Office of Human Resources | Box 1040 | Edwardsville, IL 62026 | Phone: 618.650.2190 | Fax: 618.650.2646 | benefitshr@siue.edu

Employee's Name (Last, First): _____ Banner ID: 800 _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____
2. Probable duration of condition: _____
3. 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) of discharge: _____
4. Date(s) patient was seen in your office for condition: _____
5. Medical diagnosis of condition: _____
6. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No
7. Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No
   If yes, what was prescribed? _____
8. 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 treatments and expected duration of treatment: _____
   _____
9. Describe relevant medical facts related to the above condition for which the employee seeks leave including symptoms, or any regimen of continuing treatment. _____
   _____

PART B: AMOUNT OF LEAVE NEEDED

10. 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 so, estimate the beginning and ending dates for the period of incapacity: _____

Note: Upon return to work, employees must retain a statement from the attending physician that he/she is able to resume work.

11. Will the employee need to attend follow-up treatment appointments? ☐ Yes ☐ No
    If so, what are the treatments and are they medically necessary? _____
    _____
12. Will the employee need to work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No
    If so, Estimate the part-time or reduced work schedule the employee needs, if any:
    _____ hour(s) per day; _____ days per week from _____through _____
13. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____
14. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
    ☐ Yes ☐ No

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

If so, explain: _____

16. 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. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ days(s) per episode

PLEASE LIST ANY ADDITIONAL INFORMATION HERE:

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider: _____

Printed Name: _____

Type of Practice: _____

Telephone: _____

Mailing Address: _____

Date: _____

FOR HR OFFICE USE ONLY

H.R. Approval: ☐ Yes ☐ No Authorized Signature: _____

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. `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.