Certification of Health Care Provider

1. Employee's Name _____
2. Patient's Name (if other than employee) _____
3. A description of what is meant by a serious health condition under FMLA is listed on page 2 of this form.

   Does the patient's condition qualify under any of the categories described? ☐ Yes ☐ No

   If yes, please indicate the applicable category: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
4. Date condition commenced _____ Probable Duration of Condition _____
5. State schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule.

_____

_____

If this certification relates to the employee's own health condition, complete items 6 through 8 and proceed to items 12 through 13. Answer item 8 after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.

6. ☐ Yes ☐ No Is inpatient hospitalization of the employee required?
7. ☐ Yes ☐ No Is employee able to perform work of any kind?
8. ☐ Yes ☐ No Is employee able to perform the functions of employee's position?

If this certification relates to caring for the employee's seriously ill family member, complete items 9 through 11 as they apply to the family member and proceed to items 12 through 13.

9. ☐ Yes ☐ No Is patient hospitalization of the family member (patient) required?
10. ☐ Yes ☐ No Does (or will) the patient require assistance for basic medical, hygiene, nutritional, safety, or
11. ☐ Yes ☐ No After reviewing the employee's signed statement, is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
12. Estimated time care is needed or employee's presence is needed _____
13. Health Care Provider Information:

_____ _____
Physician's Name Type of practice

_____ _____
Address Phone

_____ _____
Signature Date

To be completed by employee needing leave to care for a family member:

State the care you will provide, and an estimate of the time period care will be provided, including a schedule if leave is to be taken intermittently.

_____

_____

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 employees or their family members. In order 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.

_____ _____
Signature of Employee Date

University of Nebraska Lincoln

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Description of what is meant by *Serious Health Condition* under the Family and Medical Leave Act (FMLA) of 1993.

A "**Serious Health Condition**" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

a. A period of incapacity **of more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   i. **Treatment two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

   ii. **Treatment** by a health care provider **on at least one occasion** which results in **a regimen of continuing treatment** under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

a. Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

b. Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

c. May cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-Term Conditions Requiring Supervision

A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under continuing supervision of, but need not be receiving active treatment by, a health care provider.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of **absence** to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).