University of New Hampshire

Employee Health Certification - Form A

SECTION 1: TO BE COMPLETED BY EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: *Please complete Section 1 before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).*

_____ _____

Employee's Name (Last, First, MI) SS# (Last 4 Digits)

_____ _____

Home Address (Street, City State, Zip) UNH Department

I authorize release of the information requested on this form to support my medical leave request.

_____ _____/_____/_____

Employee Signature Date

Check if your job description or task analysis is attached ☐

SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER

Your patient 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 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 FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Part A: Medical Facts

1. Approximate date the condition commenced _____/_____/_____

Probable duration of the condition _____
(# of weeks/months/days)

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?
No ☐ Yes ☐ If so, dates of admission: _____

Dates you treated the patient for condition: _____

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

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

Was the patient referred to other health care providers(s) for evaluation or treatment? No ☐ Yes ☐
(e.g., physical therapist)

If so, state the nature of such treatments and expected duration of treatment: _____

_____

2. Is the medical condition pregnancy? No ☐ Yes ☐ If yes estimated due date _____/_____/_____

3. If a job description is not provided with this form, answer these questions based upon the employee's own

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description of his/her job functions.
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
Beginning Date _____/_____/_____ End Date _____/_____/_____

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 ☐
Estimate the part-time or reduced work schedule the employee needs, if any:
_____ hour(s) per day; _____ days per week from: _____/_____/_____ through _____/_____/_____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions No ☐ Yes ☐
Is it medically necessary for the employee to be absent from work during the flare-ups?
No ☐ Yes ☐ If so, 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 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

Return to work

If known, what is the actual date the employee can return to work full duty? ____/____/____

Provider's Signature

Providers Name: _____
Address: _____
Phone: _____
Signature: _____
Date: _____/_____/_____

Fax or mail completed form to:
UNH Human Resources
2 Leavitt Lane
Durham, NH 03824
Fax# 603-862-5159