

The University of Tennessee Space Institute
Human Resources and Services
411 B. H. Goethert Parkway
Tullahoma, TN 37388-9700
Certification of Health Care Provider
(Family and Medical Leave Act)

Please return the completed form to UTSI Human Resources, 411 B.H.
Goethert Parkway, Tullahoma, TN 37388-9700 or fax to (931) 393-7268.

OMB: 1215-0181
Expires: 12/31/2011

For Completion by the HEALTH CARE PROVIDER-INSTRUCTIONS to the 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. Please be sure to sign the form on the last page.

Patient's Name:

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

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: _____

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 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:

2. 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

3. Will the patient 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:

Estimate the part-time or reduced work schedule the employee needs; if any:

_____hour(s) per day; _____days per week from _____ through _____

5. Will the condition cause episodic flare-ups periodically preventing the patient 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, 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 ___ day(s) per episode

ADDITIONAL INFORMATION IF NECESSARY: IDENTIFY QUESTION NUMBER WITH YOUR
ADDITIONAL ANSWER.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT OR UTSI HUMAN RESOURCES, 411 B.H. Goethert Parkway, Tullahoma, TN 37388-9700 OR FAX TO (931) 393-7268.**