The City University of New York

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

Section 1: TO BE COMPLETED BY EMPLOYER

College _____ Address _____

City _____ State _____ Zip Code _____ Tel.: _____ FAX _____

Name of Employee _____ Empl. ID _____ Department _____

Contract Title _____ ☐ ***Job description attached*** Regular Work Schedule _____

Essential Job Functions
(If job description is not attached) _____

Section II: INSTRUCTIONS TO EMPLOYEE

FMLA permits CUNY 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 CUNY, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request.

CUNY gives you at least 15 calendar days to return this form.

This form must be returned by _____

Section III: INSTRUCTIONS TO HEALTH CARE PROVIDER

The employee listed above 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 care.
- Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

PLEASE PRINT CLEARLY OR TYPE. SIGN THE FORM ON THE LAST PAGE (PAGE 4).

Health Care Provider's Name _____

Telephone _____ FAX _____

Address _____

City _____ State _____ Zip Code _____ Country _____

Type of Practice /Medical Speciality:

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

PART A: MEDICAL FACTS

Approximate date condition commenced _____ Probable duration of condition _____

Answer as applicable

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, dates of admission From _____ To _____

Dates you treated the patient for a condition _____

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

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

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:

Is the medical condition pregnancy? ☐ Yes ☐ No If yes, expected date of delivery _____

Use the information provided by the Employer in Section 1 to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job.

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

If yes, identify the job functions the employee is unable to perform:

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):

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

PART B: AMOUNT OF LEAVE NEEDED

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 yes, estimate the beginning and end dates for the period of incapacity: From _____ To _____

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? ☐ Yes ☐ No

If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

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 _____

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

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

If yes, 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., episode every 3 months lasting 1-2 days):

Frequency No. of times per week _____ No. of times per month _____

Duration No. of hours per episode _____ No. of day(s) per episode _____

ADDITIONAL INFORMATION:

IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

PRINT NAME OF HEALTH CARE PROVIDER _____

SIGNATURE OF HEALTH CARE PROVIDER _____

LICENSE # _____

DATE _____