TEXAS A&M UNIVERSITY CORPUS CHRISTI | HUMAN RESOURCES
OUR SERVICES - YOUR FUTURE

Certification of Physician or Practitioner

Instructions : This form must be completed by a physician or practitioner. It is used by departments to request hours from the Sick Leave Pool (SLP), to ensure accountability for the use of sick leave, and to gather information for Family and Medical Leave Act and Parental Leave eligibility. This completed form, or an equivalent and otherwise acceptable form, must be submitted within the required deadlines where SLP hours, sick leave, or FMLA leave is requested. ***Please do not use abbreviations on any of the fields.***

1. Employee's Name	**1a. Date**
2. Department Name	**2a. UIN**

3. Patient's Name (if other than employee)

Patient's relationship to employee: ☐ Spouse ☐ Parent ☐ other _____ ☐ Child → If child, list age: _____

4. Medical facts, symptoms, diagnosis of condition (additional space provided in box 15)	**5. Is condition pregnancy?** ☐ Yes ☐ No If yes, expected delivery date:_____
6. Estimated date condition commenced	**7. Estimated duration of condition** ☐ Lifetime ☐ Unknown or Undetermined ☐ Other (#days/weeks etc)_____ ☐ Ending Date, if known _____

8. FMLA ELIGIBILITY: Please check any applicable category or categories relating to the patient's or employee's medical condition:

a. ☐ **Incapacity of More Than Three Calendar Days -** This period of incapacity involves:
- treatment two or more times by a health care provider;
- treatment by a health care provider on at least one occasion with prescribed medication; and/or
- treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment, including prescriptions

b. ☐ **Pregnancy** – Any period of incapacity due to pregnancy or for prenatal care.

c. ☐ **Hospital Care** – inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility

d. ☐ **Intermittent Incapacity / Chronic Conditions Requiring at Least Two Treatments Per Year**
- May cause episodic rather than continuing periods of incapacity
- Examples: migraine headaches, diabetes, fibromyalgia

e. ☐ **Permanent/Long-term Conditions Requiring Supervision** – Examples: Alzheimer's, severe stroke, terminal illness

f. ☐ **Multiple Treatments (Non-Chronic Conditions)** – Examples: physical therapy for severe arthritis or dialysis for kidney disease

g. ☐ **None of the Above.**

Boxes 9 and 10 relate to EMPLOYEE'S health condition; FAMILY MEMBER condition details on next page

9. AMOUNT OF LEAVE NEEDED: Please check the following statement(s) that apply to the EMPLOYEE'S medical condition resulting from the injury or illness based on the employee's attached job description or the employee's own description of his/her job duties:

a. ☐ The employee **may return to work without restrictions.** Return to work date: _____.

b. ☐ The employee **may not return to work until further evaluation** on _____ (date).

c. ☐ The employee may return to work, but **may miss work on an episodic basis as a result of flare-ups.** 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 the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per ☐week ☐month **Duration:** _____ ☐hour(s) or ☐day(s) per episode.

d. ☐ The employee **may return to work with restrictions.**

☐ A reduced work schedule is needed at ____ hours per day, ____ days per week from _____(date) through _____(date).

☐ The following work restrictions are recommended (additional information may be provided in box 14):

10. FOLLOW-UP APPOINTMENTS, REGIMEN OF TREATMENT, ETC.: Please complete all that apply to the EMPLOYEE'S Condition:

a. Will the employee need to attend follow-up treatment appointments because of his/her medical condition? ☐Yes ☐No

b. If Yes to item 10a, please provide the date(s) of the scheduled appointments. If date(s) are not firm, please estimate:_____

This page relates to the employee's care of his/her FAMILY MEMBER referenced in Box 3:

11. AMOUNT OF LEAVE NEEDED FOR PATIENT IN BOX #3: Please check the following statement(s) that apply to the patient's need for the employee's care resulting from the injury or illness; additional information may be provided in Box14:

a. ☐ The employee **may return to work,** as the patient no longer requires care. Return to work date: _____.

b. ☐ The employee **may not return to work and is needed to care for the patient on a full-time basis** until reevaluation _____ (date)

c. ☐ The employee may return to work, but **may miss work on an episodic basis as a result of flare-ups.** 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 the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per ☐ week ☐ month **Duration:** _____ ☐ hour(s) or ☐ day(s) per episode.

12. FOLLOW-UP APPOINTMENTS, REGIMEN OF TREATMENT, ETC.: Please check all that apply to the PATIENT'S Condition:

a. Will the employee be needed to assist the patient to attend follow-up treatment appointments because of his/her medical condition?
Yes ☐ **No** ☐

b. If Yes to item 13a, please provide the date(s) of the scheduled appointments. If date(s) are not firm, please estimate:

13. EMPLOYEE: Describe the care you will provide to your family member and estimate the leave needed to provide the care:

14. PRACTITIONER: Please check the patient's need for medical assistance from the employee:
☐ psychological comfort ☐ hygiene ☐ basic medical care ☐ transportation ☐ therapy ☐ nutrition

☐ other:_____

15. PRACTITIONER: Please give any additional information, if any, relative to previous questions in this form:

Practitioner: 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 of 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 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.

X_____ _____ _____
Practitioner Signature **Date** **Phone**

_____ _____
Practitioner PRINTED Name **Type of Practice / Medical Specialty**

Questions?
HR Leave | (361) 825-3931 | leave@tamucc.edu