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

EMPLOYEE'S CONDITION — Certification of Health Care Provider Form

Employee Instructions: This form must be completed by a practitioner regarding the employee's health condition. The employee should provide this information to his/her department for the purposes of sick leave usage, sick pool eligibility, and Family and Medical Leave Act (FMLA) eligibility.

Physician's Instructions : 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 an individual or family member of the individual, except as specifically allowed by this law. 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.

1. Texas A&M Employee Name	**2. Employee's Job Title**

MEDICAL FACTS

3. Medical facts, symptoms and / or diagnosis of condition:

3a. Is condition pregnancy? ☐Yes ☐No **If yes, estimate delivery date:**

4. Approximate date condition commenced:	**5. Probable duration of condition:** ☐ Lifetime ☐ Unknown ☐ Ending date, if known:

FMLA ELIGIBILITY

6. Please check any applicable category or categories relating to the 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.**

OTHER MEDICAL FACTS

7. Please refer to the attached position description or to the knowledge of employee's job duties:

Is the employee unable to perform any of his/her job functions due to the condition? ☐No ☐Yes If yes, identify the job functions the employee is unable to perform and provide any work restrictions that would allow the employee to return to work:

7b. Next evaluation date regarding job restrictions:

AMOUNT OF LEAVE NEEDED

8. Please refer to the attached job description or to your knowledge of employee's job duties:

a. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for recovery?
☐No ☐Yes → If yes, estimate the beginning date of incapacity________________and estimate the return to work date_____________________.

b. Will the employee need to remain off work until another medical evaluation? ☐No ☐Yes → if yes, give next date of evaluation: ______________.

c. Will the employee need to work part-time or on a reduced hour schedule because of the employee's medical condition? ☐No ☐Yes
If yes, estimate the part-time or reduced work schedule the employee needs:

_____ hours per day, _____ days per week from _______________ (date) through _______________ (date).

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

9. FOLLOW-UP APPOINTMENTS, REGIMEN OF TREATMENT, ETC.:
Will the employee need to attend follow-up treatment appointments (physical therapy, etc.) because of his/her medical condition? ☐Yes ☐No

If Yes→ Please provide the date(s) of the scheduled appointments. If date(s) are not firm, please estimate:

OTHER RELEVANT MEDICAL FACTS

10. PHYSICIAN: Describe other relevant medical facts, if any, related to the items above for which the employee seeks medical leave (medical facts may include symptoms, diagnosis, or treatment, including specialized equipment):

Physician's Signature: ____ Date: ____

Physician's Printed Name: _____________________________________ Telephone Number: ________________________________

Field of Specialty: ____ Fax Number: ______________________________________

SUBMIT FORM TO

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