UNIVERSITY of SOUTH FLORIDA

CENTRAL HUMAN RESOURCES
Medical Leave of Absence
Medical Certification
Administrative and Staff Employees

This Medical Leave of Absence Certification must be completed by a USF Employees' health care provider when submitting a request for a medical leave of absence due to an employee serious health condition. The Medical Leave of Absence Certification must be returned to FMLA@usf.edu **within 15 calendar days**. If the employee fails to provide complete and sufficient medical certification, his or her medical leave of absence request may be denied.

Section I - Employee

Either the employee or the employer may complete Section I. This form asks the health care provider for the information necessary for a complete and sufficient medical certification.

(1) Employee name: _____
First *Middle* *Last*

(2) Dates requesting leave: _____ to _____ Employee's job title: _____

(3) Employee's essential job functions (attach a copy of job description): _____

_____

Section II - Health Care Provider

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested to take a Medical Leave of Absence from the University of South Florida due to the employee's serious health condition. A "serious health condition" is defined as an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking medical leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed.

Note: For medical leave of absence purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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).

Description of Medical Condition: _____

State the approximate date the condition started or will start: _____ and **best estimate** of how long the condition lasted or will last: _____ (MM/DD/YY Dates only, please do not state unknown or indeterminate)

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

If yes, date(s) of admission: _____ Dates you treated the patient for condition: _____

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

The patient (☐ was / ☐ will be) seen on the following date(s): _____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).*

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If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks medical leave. *(e.g., use of nebulizer, dialysis*)_____

Does this patient have a physical or mental impairment ☐ Yes ☐ No
If so, please identify/state the impairment_____

In your medical opinion, does the patient's medical condition limit his or her ability to perform any major life activities?
☐ Yes ☐ No

If "Yes", please select all major life activities that are limited by the patient's medical condition:

Employee's Affected Major Life Activities:

☐ Seeing	☐ Eating	☐ Performing Manual Tasks
☐ Hearing	☐ Sleeping	☐ Learning, Reading, Concentrating, Thinking
☐ Speaking, Communicating	☐ Breathing	☐ Caring for Self
☐ Walking Standing Lifting, Bending	☐ Working	☐ None

Employee's Affected Major Bodily Functions:

☐ Immune System	☐ Respiratory	☐ Digestive, Bowel, Bladder
☐ Endocrine	☐ Circulatory	☐ Neurological, Brain
☐ None		

In your medical opinion, for each major life activity identified, is the patient materially (less than significantly but more than moderately) restricted in his or her ability to perform that activity, as compared to the ability of an average person in the general population? If so, please explain:

_____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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 if an employee is eligible for a medical leave of absence.

(1) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) the following date(s): _____

(2) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).State the nature of such treatments: _____

Provide your **best estimate** of the beginning date _____ and end date_____ for the treatment(s) and your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week):*

_____

(3) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.
Provide your **best estimate** of the reduced schedule the employee is able to work. From _____*(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

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(4) Due to the condition, the patient (☐was /☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery. Best estimate of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(5) Due to the condition, it (☐ was / ☐ is /☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Episodes of incapacity are estimated to occur _____ times per (☐day /☐ week /☐ month) and are likely to last approximately_____ (☐ hours / ☐ days) per episode.

PART C: Essential Job Functions

If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

Due to the condition, the employee (☐was not able / ☐is not able /☐ will not be able ☐ has limitations) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform, or describe the frequency and severity of the limitations:

_____

_____

Do you know of any job modification(s) or other accommodation(s) that would enable the patient to perform the job functions you identified? ☐ Yes ☐ No

If "Yes", please describe in detail the suggested modification(s) or other accommodation(s).

_____

_____

_____

Signature of Health Care Provider _____ **Date** _____

Please send completed form to FMLA@usf.edu.