



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 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.

1. TAMHSC Employee Name	2. Date
3. Patient Name (if other than employee): _____ Relationship to employee: <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> other _____	
4. Medical facts, symptoms, diagnosis of condition (additional information may be noted in Box 14):	
5. Estimated date condition commenced:	6. Estimated duration of condition: <input type="checkbox"/> Lifetime <input type="checkbox"/> Unknown or Undetermined <input type="checkbox"/> Other (#days/weeks etc) _____ <input type="checkbox"/> Ending Date, if known _____
7. FMLA ELIGIBILITY: Please check any applicable category or categories relating to the <u>patient's or employee's</u> medical condition: a. <input type="checkbox"/> 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. <input type="checkbox"/> Pregnancy – Any period of incapacity due to pregnancy or for prenatal care. Estimated date of delivery: _____ c. <input type="checkbox"/> Hospital Care – inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility d. <input type="checkbox"/> 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. <input type="checkbox"/> Permanent/Long-term Conditions Requiring Supervision – Examples: Alzheimer's, severe stroke, terminal illness f. <input type="checkbox"/> Multiple Treatments (Non-Chronic Conditions) – Examples: physical therapy for severe arthritis or dialysis for kidney disease	

Boxes 8 and 9 relate to EMPLOYEE'S health condition; FAMILY MEMBER condition details on next page

8. AMOUNT OF LEAVE NEEDED: Please check the following statement(s) that apply to the EMPLOYEE'S medical condition resulting from the injury or illness <u>based on the employee's attached job description</u> or the employee's own description of his/her job duties: a. <input type="checkbox"/> The employee may return to work without restrictions. Return to work date: _____ b. <input type="checkbox"/> The employee may not return to work until further evaluation on _____ (date). c. <input type="checkbox"/> The employee may return to work, but may miss work on an episodic basis as a result of flare-ups. <u>Estimated</u> episodic leave: Physician – Please check one: Up to # _____ hours per day OR Up to # _____ days per week OR Up to # _____ days per month Need for episodic leave above expected to last through _____ (date) d. <input type="checkbox"/> The employee may return to work with restrictions. Based upon the employee's position description or his /her descriptions of the duties, please provide restrictions, including the expected duration of the restricted work (additional space provided in Box 14):
9. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No b. If Yes to item 9a, please provide the estimated date the scheduled appointments will end: _____ NOTICE TO EMPLOYEE: You will be required to provide your department with the times and dates of scheduled appointments relevant to the condition described in this form; your failure to provide this information may result in the delay or denial of applicable benefits. You may be requested to provide this schedule with a practitioner's signature to verify the times of treatment.



HEALTH SCIENCE CENTER

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

10. Please check all that apply regarding the employee's care that is necessary to the patient referenced in box #3:

☐ Psychological Comfort ☐ Basic Medical Care and Hygiene ☐ Transportation ☐ Safety ☐ Other: Please explain in box 14

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 Box 14:

- 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 on _____ but **may miss work on an episodic basis due to flare-ups** to care for the patient. The **estimated** need for episodic leave: **(Physician: Please check one)**

Up to # _____ hours per day **OR** Up to # _____ days per week **OR** Up to # _____ days per month

Need for episodic leave expected to last through _____ (date)

Additional information may be provided in Box 14

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 12a, please provide the **estimated date** the scheduled appointments will end: _____

NOTICE TO EMPLOYEE: You will be required to provide your department with the times and dates of scheduled appointments relevant to the condition described in this form; your failure to provide this information may result in the delay or denial of applicable benefits. You may be requested to provide this schedule with a practitioner's signature to verify the times of treatment.

13. EMPLOYEE: To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be used intermittently or if it will be necessary for you to work less than a full schedule. You may attach additional pages if necessary:

☐ **Please check if additional page(s) have been submitted with this document**

Employee Signature _____ Date _____

14. PHYSICIAN: Please note additional items regarding patient and/or employee; you may attach additional pages if necessary:

☐ **Please check if additional page(s) have been submitted with this document**

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 service

X _____
PRACTITIONER SIGNATURE

Date

Phone

Practitioner PRINTED Name

Type of Practice / Medical Specialty

SUBMIT FORM TO:
Your Department's FMLA or Leave Administrator

NEED HELP?
Phone (979) 458-7243
benefits@tamhsc.edu