CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

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SECTION I: INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to the medical provider.

Employee's Full Name: _____ *myWSU* ID # _____

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave required to provide care:

_____

_____

_____ _____

Employee's Signature Date

SECTION II: INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested medical leave to care for your patient. Answer fully and completely, all applicable parts below . 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 leave coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's Name: _____

Provider's Address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ **Fax:** (_____) _____

MEDICAL FACTS

Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes If yes, dates of admission: _____

Date(s) you treated the patient for condition: _____

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

☐ No ☐ Yes If yes, state the nature of such treatments and expected duration of treatment:

_____

_____

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

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):

_____

_____

AMOUNT OF CARE NEEDED

Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any

time for treatment and recovery? ☐ No ☐ Yes

If yes, estimate the beginning and ending dates for the period of incapacity: _____ to _____

During this time, will the patient need care? ☐ No ☐ Yes

Explain the care needed by the patient, and why such care is medically necessary: _____

Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ day(s) per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ 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 that the patient may have over the next six months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode.

Does the patient need care during these flare-ups? ☐ No ☐ Yes

Explain the care needed by the patient, and why such care is medically necessary: _____

Additional Information – Identify Question with Your Additional Answer:

_____ _____

Signature of Health Care Provider Date

* "Incapacity," for purposes of medical leave, is defined to mean inability to work, attend school or perform other regular activities due to the serious health condition, treatment therefore, or recovery therefrom.

*Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

* A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic), or therapy requiring special equipment to resolve or alleviate the health conditions. A regimen of treatment does not include the taking of over-the-counter medications such as Aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Paperwork Reduction Act Notice and Public Burden Statement

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500.Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT OR TO WICHITA STATE UNIVERSITY HUMAN RESOURCES.**