



CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993; Rev. 01/09)
Wichita State University *Office of Human Resources* Wichita, Kansas 67260-0015
Phone- (316) 978-3065* Fax- (316) 978-3201

(Rev. 1/2011)

- 1. Employee's Full Name: myWSU ID #
2. Employee's Job Title: Regular Work Schedule:
3. Employee's Essential Job Functions:
4. Patient's Name (if different from employee): Relationship to Employee:
If family member is your son or daughter, Date of Birth:

Completion by the HEALTH CARE PROVIDER Required

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA either for him/herself or to care for a family member. Answer, fully and completely, all applicable parts. 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 employee/patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on page 3 and complete page 4 if required.

- 5. Diagnosis: 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 for instance the use of specialized equipment):

- 6. Was this employee/patient seen by the Physician or Health Care Provider?
7. Was the employee/patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
8. Will the employee need to have treatment visits at least twice per year due to the condition?
9. Approximate Date Condition Commenced: Probable Duration of Condition:
10. Was the employee referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
*State the Probable Duration and Nature of TREATMENT(s)

- 11. Is the medical condition Pregnancy?
12. Use the information provided by Wichita State University in question #3 to answer this question. If WSU failed to provide a list of the employee's essential functions or a position description, answer these questions based upon the employee's own description of his/her job functions.
a. Is the employee unable to perform any of his/her job functions due to the condition:
If yes, identify the job functions the employee is unable to perform:

13. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? Yes No
If yes, estimate the beginning and ending dates for the period of incapacity: from _____ to _____
14. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? Yes No
If yes, are the treatments or the reduced number of hours of work medically necessary? Yes No
a. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

b. Estimate the part-time or reduced work schedule the employee needs, if any:
_____ hour(s) per day; _____ days per week from _____ through _____
15. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? Yes No
Is it medically necessary for the employee to be absent from work during the flare-ups? Yes No
If yes, explain: _____

a. 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 6 months (e.g., one episode every three months lasting one to two days):
Frequency: _____ times per _____ week(s) _____ month(s).
Duration: _____ hours or _____ day(s) per episode.
16. If leave is required to **care for an eligible family member** (of the employee), describe the care needed by the patient and why such care is medically necessary: _____

17. Will the **eligible family member** require follow-up treatments, including any time for recovery? Yes No
a. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

b. Explain the care needed by the **eligible family member**, and why such care is medically necessary:

18. Will the **eligible family member** require care on an intermittent or reduced schedule basis, including any time for recovery? Yes No
a. Estimate the hours the eligible family member needs care on an intermittent basis, if any:
_____ hour(s) per day; _____ days per week from _____ through _____
b. Explain the care needed by the **eligible family member**, and why such care is medically necessary:

19. Will the condition cause episodic flare-ups periodically preventing the **eligible family member** from participating in normal daily activities? Yes No
- a. Based upon the eligible family member'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 6 months (e.g., one episode every three months lasting one to two days):
- Frequency: _____ times per _____ week(s) _____ month(s)
- Duration: _____ hours or _____ day(s) per episode.
- b. Does the **eligible family member** need care during these flare-ups? Yes No
- c. Explain the care needed by the **eligible family member**, and why such care is medically necessary:

(Signature of Health Care Provider)

(Type of Practice/Medical Specialty)

(Health Care Provider Name) **Please Print**

(Date)

(Address)

(Telephone Number)

(City)

(State) (Zip)

The Genetic Information Non-Discrimination Act of 2008 (GINA) for FMLA

The Genetic Information Non-Discrimination 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 individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **The GINA Title II does allow you to provide information about the medical condition of an employee's spouse, parent or child to certify the need for leave under the Family and Medical Leave Act (FMLA).**

¹Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

²"Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

³Treatment 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.

⁴A 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.

Continue to Page 4 to complete the Return to Work Authorization form.

RETURN TO WORK AUTHORIZATION

Rev. 02/2011

Employee Name: _____ myWSU ID#: _____
 Department Name: _____ Campus Box # _____
 Supervisor's Name: _____

***I have taken into consideration the job description and this patient may return to:**

_____ Regular Duty as of _____
 _____ Modified Duty as of _____ Until Date: _____

with the following restrictions:

- | | |
|--|--|
| _____ No Repetitive Gripping | _____ Awkward Position |
| _____ No Repetitive Bending/Twisting | _____ Limited Outside Work |
| _____ No Repetitive Lifting | _____ Limited Exposure Extreme Heat/Cold |
| _____ No Pushing/Pulling/Reaching | _____ No Dust/Mold/Fumes/Smoke/Gases |
| _____ No Lifting Above Shoulder Level | _____ No Exposure Chemicals |
| _____ No Lifting Above Waist Level | _____ Limited Walking/Running/Jumping |
| _____ No Squatting/Crawling/Kneeling | _____ No Repetitive Turning |
| _____ No Driving Motor Vehicles | _____ No Repetitive Stooping |
| _____ No Climbing | _____ Limited Sitting/Standing |
| _____ Weight Limit _____ lbs. | _____ Limited Balancing/Carrying/Holding |
| _____ Other, please specify: _____ | |

Physician Comments: _____

 Examining Physician Name (Please Print)

 Type of Practice/Medical Specialty

 Examining Physician Signature

 Date

 Examining Physician Address

 Phone Number

 Employee Signature

 Date

Return to Human Resources, FMLA Coordinator, Box 15.