Certification of Physician or Practitioner

Privacy Notice to Employees: State law requires that you be informed that you are entitled to: (1) request to be informed about the information collected about yourself on this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge. Contact: hrcompbenefits@tamu.edu or (979) 862-1718.

Instructions : This form must be completed by a physician or practitioner and 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 must be submitted in a timely manner where SLP hours are requested, as state law prohibits retroactive pay from the pool. Employees must return this completed form to the department to account for and use FMLA leave and/or request sick leave pool hours.

1. Employee Name	**2. Date**
3. Patient Name (if other than employee):	**Relationship to employee:** ☐ Child ☐ Spouse ☐ Parent ☐ other ______________________

4. Medical facts, symptoms, diagnosis of condition (additional information may be noted in box 12):

☐ Surgery is/was required; date of surgery (estimated date, if necessary): ____

5. Estimated date condition commenced:	**6. Estimated duration of condition:** ☐ Lifetime ☐ Unknown or Undetermined ☐ Other (#days/weeks etc)______________ ☐ Specific Ending Date, if known ______________ *Please ensure that all applicable boxes are completed in items 7-12 to ensure benefits eligibility.

7. FMLA Eligibility: Please check any applicable category or categories relating to the patient'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 (prescribed medication included)

b. ☐ **Pregnancy** – Any period of incapacity due to pregnancy or for prenatal care. Estimated date of delivery: _________________

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

8. If applicable, please describe any regimen of treatments (additional comments may be provided in box 12):

IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP BOX 9 AND PROCEED TO ITEMS 10-13 ON REVERSE SIDE; OTHERWISE, PLEASE CONTINUE AND SIGN ON PAGE 2:

9. Please check the following statement(s) that apply to the employee's medical condition resulting from the injury or illness:

a. ☐ The employee may return to return to work **without restrictions.** Return to work date: _________________.

b. ☐ The employee **may not return to work until further evaluation** on __________________ (date).

c. ☐ The employee may return to work, but **may miss work on an episodic basis.** The **estimated** need for episodic leave, including treatments, is:

#______ ☐hours ☐days **per** ☐ day ☐week ☐month and is expected to last through __________________ (date).

d. ☐ The employee may return to work as of _________________(date) **with the following restrictions*:**

e. Other:*

***Additional comments may be provided in box 12**

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, PLEASE COMPLETE ITEMS 11 THROUGH 14 AND SIGN/DATE BELOW:

10. Please check all that apply if the employee is needed to medically care for the patient listed in box 3:

☐ Psychological comfort where the employee's presence is beneficial to the patient's well-being , even where the employee may not be needed for direct medical care

☐ Basic Medical Care and Hygiene ☐ Transportation ☐ Safety ☐ Other ______________________________________

Additional Comments (if needed to explain why such care is medically necessary):

***Additional comments may be provided in box 12**

11. Please check the following statement(s) that apply to the patient's medical condition resulting from the injury or illness:

a. ☐ The employee **may return to 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 of evaluation: _________________.

c. ☐ The employee may return to work on ____________________ (date). , but **may miss work on an episodic basis** as required by the patient. The **estimated** need for episodic leave, is:

#_______ ☐hours ☐days **per** ☐ day ☐week ☐month and is expected to last through ___________________ (date).

d. **Other:**

***Additional comments may be provided in box 12**

12. Additional physician or practitioner's notes/comments regarding patient, if necessary:

13. Health Care Provider Form Release:

I, the undersigned, authorize the health care provider to release this completed Certification of Health Care Provider Form to the appropriate administrators of the Sick Leave Pool, the Family and Medical Leave Act, and general leave administration of Texas A&M University for the purposes of FMLA and sick leave compliance:

Employee Signature____ Date___________________________

Signature of Physician or Practitioner ____ Date ________________________

Physician or Practitioner (PRINTED NAME) ____ Phone ________________________

Type of Practice (Field of Specialization, if any) ____

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

NEED HELP?
Benefits Services
Phone (979) 862-1718
hrcompbenefits@tamu.edu