Division of Human Resources
& Organizational Effectiveness

Certification of Health Care Provider Form – Employee's Condition

Employee Instructions: This form must be completed by a practitioner regarding the employee's health condition. The employee should provide this information to his/her department for the purposes of sick leave usage, sick pool eligibility, and Family and Medical Leave Act (FMLA) eligibility.

Physician's Instructions : 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 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 an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. ***Please do not use abbreviations on any of the fields.***

1. Employee's Name	**2. Date**
Employee's Job Title	**UIN**
Employee's Department name *(please do not abbreviate)*	

MEDICAL FACTS

3. Medical facts, symptoms and / or diagnosis of condition:

3a. Is condition pregnancy? ☐Yes ☐No **If yes, estimate delivery date:**

4. Approximate date condition commenced:	**5. Probable duration of condition:** ☐ Lifetime ☐ Unknown ☐ Ending date, if known:

FMLA ELIGIBILITY

6. Please check any applicable category or categories relating to the employee'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 (including prescriptions)

b. ☐ **Pregnancy** – Any period of incapacity due to pregnancy or for prenatal care.

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

g. ☐ **None of the Above**

OTHER MEDICAL FACTS

7. Please refer to the attached position description or to the knowledge of employee's job duties:

Is the employee unable to perform any of his/her job functions due to the condition? ☐No ☐Yes If Yes→ identify the job functions the employee is unable to perform and provide any work restrictions that would allow the employee to return to work:

7b. Next evaluation date regarding job restrictions:

AMOUNT OF LEAVE NEEDED

8. Please refer to the attached job description or to your knowledge of employee's job duties:

a. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for recovery?
☐No ☐Yes → If yes, estimate the beginning date of incapacity_____and estimate the return to work date_____.

b. Will the employee need to remain off work until another medical evaluation? ☐No ☐Yes → If yes, give next date of evaluation:

_____.

c. Will the employee need to work part-time or on a reduced hour schedule because of the employee's medical condition? ☐No ☐Yes
If yes, estimate the part-time or reduced work schedule the employee needs:

_____ hours per day, _____ days per week from _____ (date) through _____ (date).

d. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐No ☐Yes

If 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 the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per ☐week ☐month **Duration:** _____ ☐hour(s) or ☐day(s) per episode.

9. FOLLOW-UP APPOINTMENTS, REGIMEN OF TREATMENT, ETC.

Will the employee need to attend follow-up treatment appointments (physical therapy, etc.) because of his/her medical condition?

☐Yes ☐No

If Yes→ Please provide the date(s) of the scheduled appointments. If date(s) are not firm, please estimate:

_____

OTHER RELEVANT MEDICAL FACTS

10. PHYSICIAN: Describe other relevant medical facts, if any, related to the items above for which the employee seeks medical leave (medical facts may include symptoms, diagnosis, or treatment, including specialized equipment):

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Telephone Number: _____

Field of Specialty: _____ Fax Number: _____

SUBMIT FORM TO
Your Department's Leave Administrator
or Appropriate Designee

NEED HELP?
HROE Employee Relations Department
Phone: 979.862.4027 | Fax: 979.862.3610
Employee-Relations@tamu.edu

Texas A&M University Contact Information

Liaison/Admin Name:_____

Phone:_____

Email:_____

Fax:_____