Certification of Health Care Provider Form

TEXAS A&M ENGINEERING

FAMILY MEMBER'S CONDITION

Instructions: This form must be completed by a practitioner regarding the **employee's** health condition. The employee should provide this information to his/her division 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 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 services.

SECTION I: For Completion by the EMPLOYEE

Employee Name:	
Name of Patient:	**Relationship To Employee:** Child Spouse Parent Other________________
Describe the care you will provide to your family member and estimate the leave needed to provide the care.	

Employee Signature____ Date ___________________________

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Answer, fully and completely, all applicable parts. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient. Limit your responses to the condition for which the employee is seeking leave. **Please be sure to sign the last page.**

Providers name:	**Type of Practice/Field of Specialty:**
Phone Number:	**Fax Number:**

PART A: MEDICAL FACTS

Medical facts, symptoms, or diagnosis of condition:

Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment). Please check if you have attached additional statements or information.

Is condition pregnancy? Yes No **If yes, estimate delivery date:**

Approximate date condition commenced:	**Probable duration of condition:** Lifetime Unknown/Undetermined Other (# days/weeks)_____________ Ending Date, if known _______________

FMLA ELIGIBILITY

Please check any applicable category or categories relating to the patient's medical condition referenced in Section I:

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)

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

Hospital Care – Inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility

Intermittent incapacity/Chronic condition requiring at least two treatments per year
- May cause episodic rather than continuing periods of incapacity
- Examples: Migraine headaches, diabetes, fibromyalgia

Permanent/Long-term conditions requiring supervision
- Examples: Alzheimer's disease, severe stroke, terminal illness

Multiple Treatments (non-chronic conditions)
- Examples: Physical therapy for severe arthritis or dialysis for kidney disease

None of the above

PART B: AMOUNT OF LEAVE NEEDED

Please check the following statements that apply to the patient's need for the employee's care resulting from injury or Illness. Additional information may be provided as an attachment.

1. **Check all that apply regarding the patient's care needed from the employee:**

   Psychological comfort   Basic Medical and Hygiene   Transportation   Safety   Other__________________

2. **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?** Yes No
   - *If yes, estimate the beginning date of incapacity*: ________________ *estimate the return to work date:* _________________

3. **Will the employee need to remain off work to care for the patient until the patient's next medical evaluation?** Yes No
   - *If yes, please give date of next evaluation*: ______________________

4. **Will the patient require care on an intermittent or reduced schedule basis, including time for recovery?** Yes No
   - *If yes , estimate the hours the patient needs care on an intermittent basis:*

     ________hours per day, __________day(s) per week, from __________(date) through ___________date.

5. **Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?**

   Yes No
   - Will the patient need care during these flare-ups? Yes No
   - *If yes, based upon patients medical history and condition, estimate the frequency of the flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2days):*

     Frequency: __________times per __________week(s) __________month(s)

     Duration: __________hours or __________day(s) per episode

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

6. **Will the employee need to assist the patient to attend follow-up treatment appointments (physical therapy, etc.) because of the medical condition?** Yes No
   - *If yes, please provide the dates of the scheduled appointments*: ____
   - *If date(s) are not firm, please estimate*: ____

Practitioner Signature ____ Date _________________________

Practitioner PRINTED Name ____

SUBMIT FORM TO:
Your Leave Administrator

QUESTIONS?
Engineering Human Resources
979-458-7695
engineeringhr@tamu.edu