To be completed by the UT Southwestern Employee

Health Care Provider Certification Form for Serious Health Condition – Section A

(Please complete all fields on this form)

1. _____ _____ _____

Employee First Name | Employee Last Name | UTSW Person #

_____ _____

Personal/Alternate Email Address | Cell Phone #

2. Is this the first certification submittal for this specific FMLA request or is it a follow up from an incomplete certification that your Leave rep requested additional information on?

○ This is my first time submitting this certification for this specific FMLA request.

○ I am re-submitting because my certification was sent back by the Leave Administration department requesting additional information.

3. **Are you requesting this leave of absence for your own serious health condition?** ○ **Yes** ○ **No**

If No, are you requesting this leave of absence for your family member's serious health condition? ○ **Yes** ○ **No**

If Yes, for whom will you be providing care?

_____ _____ _____

Family Member's First Name | Family Member's Last Name | Date of Birth (If son or daughter)

Relationship: ○ Son ○ Father ○ Spouse
○ Daughter ○ Mother ○ Domestic Partner ○ Other _____

Describe the care you will provide for your family member: _____

_____

_____

4. Are you requesting leave to bond with your newborn child, newly adopted or foster child? ○ Yes ○ No

If **Yes**, you are required to provide proof of birth or documentation of the adoption or placement of the foster child. You are not required to provide this form unless you are requesting leave for your or your family member's serious health condition, such as incapacity related to pregnancy or childbirth.

5. If none of the above applies and you would like to request a different type of leave (i.e. Military, Leave Without Pay, etc), do not complete this form. Please contact Leave Administration for guidance at 214-648-9840 or LeaveAdministration@UTSouthwestern.edu.

6. Acknowledgement – By signing this document, I acknowledge that:
   - I have received, read and understand all pages of this document.
   - I have access to UT Southwestern's FMLA policy and procedure (EMP-256 Family and Medical Leave and EMP-256P-01 Managing Family and Medical Leave) in the *Handbook of Institutional Policies and Operating Procedures*, which is available on the intranet. If I do not have access to the intranet during my employment, I may request this policy and procedure from Leave Administration.
   - I have not made, or will not make, any alterations to the information documented by the treating health care provider.
   - I have not completed any of the questions of Section B of this form below, which is to be completed ***only*** by the treating health care provider.
   - A UT Southwestern Leave Administration representative may need to contact the treating healthcare provider to clarify or authenticate this form, and has permission to do so.
   - I affirm that both my personal mailing address and email address on file with UT Southwestern are accurate.
   - It is my responsibility to ensure this completed form, and any additional information that may be requested at a later date, are submitted to and received by Leave Administration within the timelines provided. Not doing so will risk denial of the leave request.
   - Any employee who knowingly provides false or misleading information in requesting FMLA leave may be subject to disciplinary action, up to and including termination of employment or nonrenewal of appointment.

_____ _____

Employee Signature | Date of Signature

UTSW Employee Name _____ UTSW Employee ID _____

Employee Stop Here

To be completed ONLY by the Patient's Health Care Provider
Health Care Provider Certification Form for Serious Health Condition – Section B

_____ _____
Patient First Name Patient Last Name

Section B MUST be completed by the treating health care provider to provide UT Southwestern Medical Center with a confidential certification of the patient's health conditions. This certification is needed to determine if the requested leave can be approved as FMLA leave. Please answer all applicable parts of this certification fully and completely. Several questions seek a response regarding 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. Please be as specific as you can – responses such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage. Please limit your responses to the condition for which the employee is seeking leave.

7. Approximate date condition commenced: _____/_____/_____

8. Probable duration of condition: _____

9. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? O Yes O No

   If Yes, dates of admission: _____/_____/_____ through _____/_____/_____

10. Most recent or future date(s) you treated the patient for this condition (MM/DD/YYYY):

_____

11. Will the patient need to have treatment visits at least twice per year due to this condition? O Yes O No

If Yes, provide the dates of the last 2 visits and the date of the next visit (MM/DD/YYYY): _____

12. If this leave is related to a planned procedure, please provide the date of the procedure (MM/DD/YYYY): _____

13. Was medication, other than over-the-counter medication, prescribed? O Yes O No

14. Was the patient referred to other health care provider(s) for evaluation and/or treatment (ex. Physical therapist)? O Yes O No

    If Yes, state the nature of such treatments and expected duration of treatment _____

    _____

15. Is the medical condition pregnancy? O Yes O No

    If Yes, provide the expected delivery date: _____/_____/_____ or the actual delivery date: _____/_____/_____

16. Please complete **ONLY** if the leave request is for the employee's own health condition: If you are not provided with a list of the employee's essential job functions or a job description, answer this question based upon the employee's own description of his/her job functions. Please confirm if the patient is at any time unable to perform any of his/her job functions due to the condition based on the information provided by the patient. For example, during a flare up. O Yes O No
    If Yes, identify the functions the employee is unable to perform: _____

    _____

    _____

17. Please complete **ONLY** if the leave request is for the employee's family member's health condition: Explain the care needed by the patient and why such care is medically necessary:

_____

_____

_____

18. Describe the relevant medical facts related to the condition for which the employee is seeking leave, or the condition for which the patient needs care (medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

19. For chiropractic use only:
    O Yes O No Has Subluxation of the spine been demonstrated to exist by x-ray imaging? Date of x-ray: _____/_____/_____
    O Yes O No Is the patient being treated by manual manipulation of the spine for subluxation of the spine?

UTSW Employee Name _____ **UTSW Employee ID** _____

Health Care Provider Certification Form – Section B

(To be completed by the Patient's Health Care Provider **ONLY**)

_____ _____

Patient First Name Patient Last Name

Questions 20-22, complete the columns below that apply for your patient's condition. The medical facts (Question 18) on this form must substantiate the type(s) and length of leave requested.

20. **Regular/Block/Continuous** – is indicated when the employee or family member is incapacitated and requires a single block of time away from work due to the serious health condition, including any time for treatment and recovery.

Dates of incapacity:

Start Date: _____/_____/_____ End Date: _____/_____/_____

* Please note, the dates of incapacity are *not* necessarily the dates of absence from work (ex. scheduled workdays).

21. **Intermittent** – is indicated when the employee requires leave in intermittent periods of time away from work, due to the serious health condition.

Start Date: _____/_____/_____ End Date: _____/_____/_____

Complete A and/or B as they pertain to the patient's condition.

A. Frequency of leave for episodes of incapacity/flare-ups:

_____ # of times/episodes per ***(select only one)***
O year, O month, or O week

For a duration of: ***(complete only one)***

_____ # hour(s) per episode, or

_____ # day(s) per episode

B. Frequency of leave for follow-up appointments/treatment:

_____ # of times per ***(select only one)***
O year, O month, or O week

For a duration of: ***(complete only one)***

_____ # hour(s) per appointment/treatment, or

_____ # day(s) per appointment/treatment

22. **Part-Time or Reduced Work Schedule** – is indicated when the employee requires a reduced number of hours and/or days of work, due to the serious health condition.

Start Date: _____/_____/_____ End Date: _____/_____/_____

Employee can work the following hours per week: _____ # hours per day; _____ # days per week

Treating Health Care Provider Information

_____ _____

Name (Please Print) License #

_____ _____

Type of Practice/Specialty State (location) of Practice

_____ _____

Office Phone # Office Fax #

By signing this form, you are certifying that you are the treating health care provider for this patient and this condition.

_____ _____

Treating Health Care Provider Signature Date of Signature