THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Certification of Healthcare Provider for Serious Health Condition

Type of leave: Please check box that describes your leave	☐ **Employee (self)**	☐ **Family member - Relationship:** _____ **Date of Birth:** _____

Section I: Instructions: **Employee's Department or Employee to Complete** FMLA provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. **Employee: It is your responsibility to ensure that the health care provider returns the completed form to you or Employee Health (fax: 205-975-6900; email: medleavedocs@uabmc.edu) within 15 calendar days of receipt.**

Employee Full Legal Name:		**BlazerID**	
Employee Job Title		**Employee Work Schedule**	
Supervisor/Manager:			
Supervisor/Manager Contact Info:			

Section II: For Completion by Health Care Provider – Your patient has requested leave under FMLA. Answer fully and completely all applicable parts.

Provider Name: _____

Medical Specialty: _____

Telephone: _____ Fax: _____

Section III: Does Employee or Employee Family Member have a serious health condition?	☐ Yes	☐ No

A serious health condition means an illness, injury, impairment or physical or mental condition that involves one or more of the categories below. If yes, please check the applicable category(ies). If no, please sign and date the document on page 2.

- ☐ Hospital Care (inpatient) **Date of Admission:** _____
- ☐ Absence plus Treatment (Patient is unable to work or perform other regular daily activities for more than three (3) consecutive calendar days and needs ongoing treatment.)
- ☐ Pregnancy **Expected Delivery Date:** _____
- ☐ Chronic Condition Requiring Treatment (i.e., asthma, diabetes, epilepsy, etc.)
- ☐ Permanent/Long-Term Condition Requiring supervision (i.e., Alzheimer's, severe stroke, terminal stages of a disease)

Probable Duration of condition: _____ **Approximate date condition commenced:** _____

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

☐ Yes – Provider Name _____ ☐ No

Describe the medical facts supporting the above certification:

_____

_____

_____

_____

_____

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Section IV: EMPLOYEE LEAVE ONLY Because of the condition described on page one, it is necessary for the employee to:	
☐ Take a **continuous leave** of absence on consecutive days: _____ Start Date _____ Expected End Date	☐ Take **intermittent leave** according to the following schedule or reduced schedule of hours per day or days per week: _____ _____ Frequency:_____times per_____week(s)_____month(s) Duration :_____hours or_____days(s)

Section V: FAMILY MEMBER LEAVE ONLY **Answer only if employee needs to take leave for a patient who is a family member with a serious health condition.** Because of the condition described on page one, employee needs leave to:	
☐ Assist patient's basic medical needs, hygiene/nutritional needs, or for safety and transportation purposes. ☐ Provide psychological comfort that would be beneficial to patient or assist in patient's recovery.	Identify the duration and schedule of the time needed by employee to care for patient: _____ _____

Estimate treatment schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

_____

Section VI: Signature Health Care Provider:	
Date:	

Section VII: EMPLOYEE: **Authorization to Disclose Confidential Medical Information**

I authorize this health care provider to disclose complete information to the University of Alabama at Birmingham Hospital Employee Health Services Office related to my medical case history, examinations and treatment that I have received while under his/her care. I also authorize this healthcare provider to discuss my medical case history with an authorized representative of the UAB HR Relations Office in order for that office to assess the need for a reasonable workplace accommodation if necessary.

☐ I accept	☐ I decline

Employee's Signature: _____ Date: _____