ADELPHI UNIVERSITY

CERTIFICATION OF HEALTH CARE PROVIDER
(Family and Medical Leave Act of 1993)

PART A:

1. Employee's Name:_____

2. Patient's Name (if other than employee):_____

*** <u>The Genetic Information Nondiscrimination Act of 2008 (GINA)</u>:**

- *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.*

3. Diagnosis:_____

4. Is the medical condition pregnancy? If yes, estimated delivery date:_____

5. Date condition commenced:_____

6. Probable duration of condition:_____

7. Regimen of treatment to be prescribed. (Indicate number of visits, general nature and duration of treatment, including referral to other providers of health services. Include dates patient was treated for condition, schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.) If not enough space provided below, use a separate sheet.

   a) By Physician or Practitioner:

   _____
   _____
   _____
   _____
   _____
   _____

   b) By another provider of health services, if referred by Physician or Practitioner:

   _____
   _____
   _____
   _____

ADELPHI UNIVERSITY

If this certification relates to care for the employee, complete items 8, 9, 10 and 11. For certification relating to seriously ill family member, complete items 12 through 14.

Check Yes or No in the boxes below, as appropriate:

	Yes	No	
Employee			
8.	☐	☐	Is in-patient hospitalization of the employee required?
9.	☐	☐	Is employee able to perform work of any kind? (If NO, skip item 10).
10.	☐	☐	Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee).
11.	☐	☐	Will patient have to have treatment at least twice a year due to the condition?
Family Member			
12.	☐	☐	Is in-patient hospitalization of the family member (patient) required?
13.	☐	☐	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
14.	☐	☐	After review of the employee's signed statement is the employee's presence necessary or beneficial for the care of the patient? (This may include psychological comfort.)

15. Estimate the period of time care is needed or the employee's presence would be beneficial:_____
_____

16. Signature of Physician or Practitioner:_____

17. Date:_____

18. Type of Practice (Field of Specialization, if any):_____
_____

19. Telephone Number_____ Fax_____

ADELPHI UNIVERSITY

PART B: AMOUNT OF LEAVE NEEDED

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? _____ No _____ Yes

- If so, estimate the beginning and ending dates for the period of in capacity:_____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? _____ No _____ Yes

- If so, are the treatments or the reduced number of hours of work medically necessary? _____ No _____ Yes

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

- Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from: _____ through: _____

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

- Is it medically necessary for the employee to be absent from work during the flare-ups? _____ No _____ Yes

If so, explain: _____

_____

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

Frequency:_____ times per _____ week(s) month(s)_____
Duration:_____ hours or day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____