The University of Texas at Austin

Certification of Healthcare Provider - Employee

For Completion by Employee: This form must be completed in its entirety by your healthcare provider and returned to HR within 15 calendar days. Failure to provide a complete and sufficient medical certification may result in the delay or denial of your FMLA request. If your request for FMLA also includes work restrictions, contact your supervisor to discuss alternate work options. If your restrictions are substantially limiting, are expected to continue longer than 3 months or are considered permanent, your restrictions will be referred to the campus Americans with Disabilities Act (ADA) Coordinator for evaluation. *By submitting this form to your healthcare provider, you authorize that provider to release the completed form to the administrators of the Family and Medical Leave Act at the University of Texas at Austin.*

1. UT Austin Employee's Name:	2. Employee's EID:	3. Date:

For Completion by the Health Care Provider : 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.

4. Covered Condition(s) - Describe medical facts related to the condition(s) that require the patient listed in Box 1 to be off work continuously, intermittently, or to work a reduced schedule (such facts may include symptoms, diagnosis, or any regimen of continuing treatment):

5. Estimated Duration of Condition(s):	6. Approximate date patient's condition started or will start:	7. Date employee's leave should begin:
☐ < 6 months ☐ > 6 months ☐ Lifetime ☐ Unknown/Undetermined	_____/_____/_____	_____/_____/_____

8. Eligibility for Leave - Please check each statement that applies to the patient listed in Box 1.

☐ *Incapacity Plus Treatment* - Patient will be incapacitated for more than three consecutive, full calendar days.

☐ *Inpatient Care* - Patient was or will be admitted for an overnight stay in a hospital, hospice, or residential medical care facility due to their condition.

☐ *Chronic Conditions (e.g. asthma, migraines)* - Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ *Permanent or Long Term Conditions (e.g. Alzheimer's, terminal cancer)* – Due to the condition, the patient's incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ *Conditions Requiring Multiple Treatments (e.g. chemotherapy, restorative surgery)* - Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ *Pregnancy* - Patient is pregnant and has an expected delivery date of (date): _____/_____/_____.

☐ None of the above.

9. Need for Leave or Work Schedule Adjustments - Please provide your best estimate when answering the questions for each specific scenario.

Continuous Leave

Will the patient listed in Box 1 be incapacitated for a single, continuous period of time for treatment and recovery? ☐ Yes ☐ No

If yes, please estimate the period of continuous incapacity: from (date) _____/_____/_____, to (date) _____/_____/_____.

Intermittent Leave

Will the patient listed in Box 1 have episodic flare-ups that will prevent them from performing their job functions? ☐ Yes ☐ No

If yes, please estimate how often: up to _____ time(s) per ☐ week, or ☐ month, and _____ ☐ hour(s), or ☐ day(s) per episode.

Also, please estimate how long episodic flare ups will continue: from (date) _____/_____/_____, to (date) _____/_____/_____.

Reduced Work Schedule

Will the patient listed in Box 1 need to reduce his/her work schedule due to their medical condition(s)? ☐ Yes ☐ No

If yes, please indicate how often the employee may work: _____ hours per day, _____ day(s) per week.

Also, please indicate how long this schedule should continue: from (date) _____/_____/_____, to (date) _____/_____/_____.

10. Return to Work – If you have indicated a need for intermittent leave or a reduced work schedule in Box 9, please list any return to work restrictions that will prevent the employee from performing the essential functions of their position (i.e. no lifting more than 5 pounds, no standing for more than 2 hours, etc.).

Please indicate how long these restrictions should remain in effect: from (date) _____/_____/_____, to (date) _____/_____/_____.

X_____
Healthcare Provider Signature

_____
Healthcare Provider Printed Name

_____
Date

_____
Type of Practice / Medical Specialty

SUBMIT FORM TO:
HR - Benefits & Leave
Fax: (512) 471-7008
****ANALOG FAXING ONLY****
Secure Digital Submission:
https://utexas.app.box.com/f/3d9ba2109fe14663ae6004c956ea3a49

NEED HELP?
HR - Benefits & Leave
Phone: (512) 475-8099
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