The University of Texas at Austin

Certification of Healthcare Provider- Care of Family Member

For Completion by Employee: This form must be completed in its entirety by your family member's 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. *By submitting this form to their healthcare provider, your family member authorizes 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 & EID:	2. Patient's Name:	3. Date:

4. Patient's Relationship to UT Austin employee:

☐ Child ☐ Spouse ☐ Parent ☐ Other_____ If child, please provide child's date of birth: _____/_____/_____

☐ Child over age 18 but regarded as disabled due to mental or physical condition.

5. Briefly describe the care you will provide to your family member: (check all that apply)

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Physical Care ☐ Transportation ☐ Psychological Comfort

☐ Other _____

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.

6. Covered Condition(s) - Describe the medical facts related to the condition(s) of the patient in Box 2 that require the employee in Box 1 to be off work continuously or intermittently in order to care for them (such facts may include symptoms, diagnosis, or any regimen of continuing treatment):

7. Estimated Duration of Patient's Condition(s):	8. Approximate date patient's condition started or will start:	9. Date employee's leave should begin:
☐ < 6 months ☐ > 6 months ☐ Lifetime ☐ Unknown/Undetermined	_____/_____/_____	_____/_____/_____

10. Eligibility for Leave - Please check each statement that applies to the patient listed in Box 2.

☐ *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.

11. Need for Leave - Please provide your best estimate when answering the questions for each specific scenario.

Continuous Leave

Will the employee in Box 1 need time off to care for the patient in Box 2 for a single, continuous period of time? ☐ Yes ☐ No

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

Intermittent Leave

Will the employee in Box 1 need intermittent time off to provide care for or assist the patient in Box 2 with attending follow up appointments? ☐ Yes ☐ No

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

Also, please estimate the period of time: from (date) _____/_____/_____, to (date) _____/_____/_____.

X_____

Healthcare Provider Signature

_____

Healthcare Provider Printed Name

_____

Date

_____

Type of Practice / Medical Specialty

SUBMIT FORM TO:
HR - Benefits & Leave
Secure eFax: (512) 471-7008

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