FAMILY/MEDICAL LEAVE ACT (FMLA) HEALTH CERTIFICATION FORM

EMPLOYEE, DUKE

EMPLOYEE STATEMENT

_____ _____/_____/_____ _____

FIRST NAME LAST NAME DOB DUKE UNIQUE ID

SUPERVISOR NAME: Rhea Fortune, Manager, GME T ELEPHONE No: 919-684-3491 FAX : 919-684-8565

*I authorize **Employee Occupational Health & Wellness,** or its representative, to contact the healthcare provider indicated on this form for clarification or authentication of any of the information below. I also authorize my health care provider to disclose the health information described in this Certification for the purpose of clarification. I understand that I can revoke the above authorization at any time by submitting a written request.*

_____ _____/_____/_____

EMPLOYEE SIGNATURE DATE

HEALTHCARE PROVIDER STATEMENT

The above employee has requested leave under FMLA. Please answer fully all applicable questions below and limit your responses to the condition for which the employee needs leave. Please be as specific as possible.

GINA NOTICE

The Genetic information nondiscrimination Act of 2008 (GINA) prohibits employers 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 result of an individual's or family member's genetic test, 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.

_____

HEALTHCARE PROVIDER'S NAME (PLEASE PRINT) TYPE OF PRACTICE

_____

TELEPHONE FAX E-MAIL

MEDICAL FACTS:

A. Is the medical condition pregnancy? ☐ **Yes** ☐ **No** If yes, expected delivery date_____

B. Approximate date this medical condition began _____/_____/_____ Probable duration of condition _____

C. Was our employee admitted for an overnight stay in a hospital, hospice or residential care facility? ……..☐ **Yes** ☐ **No**

If yes, Date of admission _____/_____/_____ Date of discharge _____/_____/_____

D. Please list the three most recent date(s) you have treated our employee for this condition: _____

E. Was medication, other than over-the-counter medication, prescribed?……. ☐ **Yes** ☐ **No**

F. Will the employee need treatment visits at least twice per year due to this condition? ……..…..☐ **Yes** ☐**No**

G. Was our employee referred to other healthcare provider(s) for evaluation and/or treatment? …..…….. ☐ **Yes** ☐ **No**

If yes, state the nature and expected duration of treatments:

_____

H. Please describe other relevant medical facts related to the condition for which the employee needs leave **(e.g. symptoms, diagnosis, treatment such as use of specialized equipment)** _____

_____

_____

FAMILY/MEDICAL LEAVE ACT (FMLA) HEALTH CERTIFICATION FORM – EMPLOYEE, DUKE

EMPLOYEE NAME	Duke UNIQUE ID#

HEALTHCARE PROVIDER STATEMENT (Continued)

AMOUNT OF LEAVE NEEDED:

I. Is our employee unable to perform any of their job functions* due to their condition?..... ☐ **Yes** ☐ **No**

***Answer after reviewing statement of the employee's job functions or, if not provided, after discussing with the employee.**

If yes, identify the job functions our employee is ***unable*** to perform: _____

Is inability ☐ **continuous or** ☐ **episodic?**

J. Was our employee or will our employee be incapacitated for a single continuous period of time, including time for treatment and/or recovery? …… ☐ **Yes** ☐**No**

If yes, Begin date _____/_____/_____ Date the employee can return to work _____/_____/_____

K. Is it ***medically necessary*** for the employee to have follow-up treatments/appointments for this condition? …… ☐ **Yes** ☐**No**

If yes, estimate treatment schedule:_____

L. Is it ***medically necessary*** for our employee to work part time or on reduced schedule because of this condition? ☐ **Yes** ☐ **No**

If yes, estimate part-time/reduced schedule:

_____hours(s) per day; _____day(s) OR per week from _____/_____/_____to _____/_____/_____

M. Will the condition cause episodic flare-ups preventing our employee from performing their job? …....☐ **Yes** ☐ **No**

N. Is it ***medically necessary*** for our employee to be absent from work during the flare-ups? ……..….....☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

Are there job modifications that could be implemented during flare-up to allow employee to remain at work?

☐ Yes ☐ No If yes, please list: _____

_____

O. Based upon the employee's medical history and your knowledge of the medical condition, please estimate ***both*** 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 per episode: _____hours or _____day(s)

****While it may be difficult to answer this question precisely, please give your best estimate of the frequency and duration of the flare-ups. If this information is not provided, the default frequency will be 4 times per year for 1 day.**

ADDITIONAL INFORMATION RELATED TO QUESTION ABOVE: _____

_____

_____

_____

_____

HEALTHCARE PROVIDER SIGNATURE **DATE**

Health care provider: Return completed form to employee.

Manager/supervisor: Email form to eohwfmla@dm.duke.edu or **fax** 919-660-0231

Trainee: