FAMILY/MEDICAL LEAVE ACT (FMLA) HEALTH CERTIFICATION FORM

FAMILY MEMBER, DUKE

EMPLOYEE STATEMENT

____
FIRST NAME LAST NAME DUKE UNIQUE ID

SUPERVISOR NAME: Rhea Fortune, Manager, GME T ELEPHONE No: 919-684-3491 FAX : do not use

Name of family member for whom you must provide care:

________________________________ ______/____/__________
First Middle Last DOB

Relationship of family member to you:
☐ Spouse ☐ Parent ☐ Son or daughter ☐ Duke registered same sex spouse equivalent
Describe care you must provide to your family member and estimate leave time needed to provide care:

____

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FAMILY MEMBER AUTHORIZATION: *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.*

____
SIGNATURE OF FAMILY MEMBER DATE

HEALTHCARE PROVIDER STATEMENT

The above employee has requested leave to care for a family member under FMLA. Please answer fully all applicable questions below and limit your responses to the condition for which your patient requires care by please be as specific as possible.

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

____
TELEPHONE FAX E-MAIL

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.

Part I. 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 your patient 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 your patient for this condition: _________________________________

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

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FAMILY MEMBER, DUKE

EMPLOYEE NAME	Duke UNIQUE ID#

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

G. Was your patient 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 your patient needs leave **(e.g. symptoms, diagnosis, treatment such as use of specialized equipment)** ______________________________________

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PART II: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

I. Will your patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?
___No ___Yes.

Estimate the beginning and ending dates for the period of incapacity: ____

During this time, will your patient need care by a family member? __ No __ Yes.

Explain the care needed by your patient and why such care is medically necessary:

____

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____

J. Will your patient require follow-up treatments, or other intermittent care including any time for recovery requiring care by family member? ___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:

____

Explain the care needed by your patient, and why such care is medically necessary (If not defined above)

____

____

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FAMILY MEMBER, DUKE

EMPLOYEE NAME	**Duke UNIQUE ID#**

Estimate the hours your patient needs care from family member on an intermittent basis, if any:

________ Hour per day; ________ day(s) per week from _________________ through ___________________

K. Will the condition cause episodic flare-ups requiring care of your patient by family member? ____No ____Yes.

Based upon your patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that your 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

Explain the care needed by your patient, and why such care is medically necessary:

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ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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Signature of Health Care Provider **Date**

Return this form via email to eohwfmla@dm.duke.edu or fax to 919-660-0231

Health care provider : Return completed form to employee