

Michigan State University
MSU Human Resources
CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION
(Family and Medical Leave Act)
FORM TWO (2)

SECTION I
FOR COMPLETION BY THE EMPLOYER

INSTRUCTIONS FOR EMPLOYER: Michigan State University requires an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. You may not ask the employee to provide more information than allowed under the FMLA regulations. You must maintain records and documents relating to medical certification, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

Department/Supervisor: _____

Contact Name: _____ Phone: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached:

SECTION II
FOR COMPLETION BY THE EMPLOYEE

INSTRUCTIONS FOR EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Michigan State University requires medical certification to retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. You must return this form within 15 calendar days.

Your name: _____
First Middle Last

SECTION III
FOR COMPLETION BY THE HEALTH CARE PROVIDER

INSTRUCTIONS FOR THE HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can, terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Michigan State University requires recertification relating to a serious health condition every six months. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice/medical specialty: _____

Telephone: _____ Fax: _____

**PART A
MEDICAL FACTS**

1. Approximate date condition began: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? No Yes
If so, dates of admission:

Date(s) you treated the patient for condition: _____

Will the patient need to have treatment/visits at least twice per year due to the condition? No Yes

Was medication, other than over-the-counter medication, prescribed? No Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? No Yes
If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? No Yes

If so, identify the job functions the employee is unable to perform: _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

**PART B
AMOUNT OF LEAVE NEEDED**

5. 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 incapacity: _____

