THE UNIVERSITY OF SOUTHERN MISSISSIPPI

Department of Human Resources

118 College Drive #5111 - Hattiesburg, MS 39406-0001
Phone: 601-266-4050 – Fax: 601-266-4541 – hr@usm.edu

Form #2F

Medical Certification for FAMILY MEMBER

SECTION 1: To be completed by the EMPLOYEE:

Name of Employee (Print): _____ ID#:_____

Department Name:_____ Box#:_____

Supervisor Name:_____

Employee home address:_____

Employee Home Phone:_____ Cell Phone:_____

My regular work hours/schedule is: _____ to _____ from _____ a.m./p.m. to _____ a.m./p.m.

I am requesting: _____ intermittent leave _____ 12 weeks FMLA all at one time

Name and relationship of family member needing your care:_____

If family member is your child provide the date of birth of the child:_____

Describe the care you will provide to your family member and estimate the time needed to provide care:_____
_____

_____

I ☐ authorize ☐ do not authorize (check one) the health care provider identified below to provide the information requested on this form for the purpose of determining my leave request. I understand that if I do not agree to this authorization, my leave request could be delayed or denied.

Employee's Signature: _____Date: _____

SECTION 2: To be completed by the HEALTH CARE PROVIDER only:

Instructions to the Health Care Provider: Your patient has indicated a need for leave under the FMLA. Answer fully and completely ALL applicable parts. Your answer should be your best estimate based on your medical knowledge and experience. **"Unknown" or "indeterminate" is not sufficient to determine FMLA coverage**. Limit your responses to the condition for which the employee is seeking leave. Failure to provide sufficient information may cause the employee's leave request to be delayed or denied.

Part A: Medical Facts:

Approximate date condition began: _____ Probable duration: _____

Mark below as applicable:

1. Was the patient admitted for an overnight stay in the hospital, hospice, or residential medical care facility?

☐ **Yes** ☐ **No** If yes, date(s) of admission:_____

2. Dates you have treated the patient for this condition: _____

3. Will the patient need to have treatment visits at least twice per year due to the condition? **Yes** ☐ **No** ☐

4. Was medication other than over-the-counter medication prescribed? ☐ **Yes** ☐ **No**

5. Is your patient reliant on others for transportation for medical care? ☐ **Yes** ☐ **No**

6. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)?
Yes ☐ No ☐

If yes, state the nature of such treatments, expected duration of treatment, and the name of other medicalprovider:_____

7. Is the medical condition pregnancy? **Yes** ☐ **No** ☐ ☐ ☐

If yes, expected delivery date:_____

Comments_____

8. Describe other relevant facts such as symptoms, diagnosis, or any regiment of continuing treatment, related to the condition for which the family member needs leave:

_____

_____

_____

Part B: Amount of Leave Needed:

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition including anytime for treatment and recovery? **Yes ☐ No ☐**

a. During this time, will the patient need care during the hours the employee works? ☐ Yes ☐ No

If yes, estimate the beginning and ending dates for the period of incapacity:

_____

If yes, explain the care and why such care is medically necessary:_____

_____

2. Will the patient require care due to follow-up treatment appointments including time for recovery during the hours the employee works? ☐ **Yes** ☐ **No**

a. If any, estimate treatment schedule including the dates of scheduled appointments and the time required for each appointment, including recovery period. _____

_____

b. Will the patient require care on an intermittent or reduced schedule including time for recovery during the hours the employee works? ☐ Yes ☐ No

If yes, please estimate the:_____ Hour(s) per day off work _____ Day(s) per week off work

If yes, explain the intermittent care and why such care is medically necessary:_____

_____

3. Will the condition cause episodic flare-ups which prevent the employee from participating in normal daily activities? ☐ **Yes** ☐ **No**

a. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of incapacity that the patient may have (e.g. an episode every 3 months lasting 1 day):

Frequency:_____# times per _____week or _____month
For: _____# hours or _____# day(s) per episode
From: _____ (date) to _____ (date)

b. Does the patient need care during these flare-ups? ☐ Yes ☐ No

If yes, explain:_____

_____

GINA Notification to Health Care Providers: 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 employees or their family members. In order 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.

Signature of Health Care Provider: _____ Date:_____

Name of Health Care Provider: _____
(Please Print)

Type of Practice/Medical specialty: _____

Address of Health Care Provider:_____

(Phone number) _____(Fax) _____(Email address)_____