THE UNIVERSITY OF
SOUTHERN MISSISSIPPI

Department of Human Resources

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Form #2E
Medical Certification for EMPLOYEE

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

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. 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:_____

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

If yes, expected delivery date:_____

Comments_____

Answer the questions as they relate to the essential functions of the employee's job.

7. Is the employee unable to perform any of his/her essential job functions due to the condition?

Yes ☐ No ☐

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

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

Part B: Amount of Leave Needed:
1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition including anytime for treatment and recovery? **Yes** ☐ **No** ☐

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

2. Will it be medically necessary for the employee to have follow-up treatments? ☐ **Yes** ☐ **No**

3. If applicable, estimate times needed for treatments, appointments, and recovery:
_____

4. Is it medically necessary for the employee to work part-time or a reduced work schedule?

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

From (date)_____ through (date)_____

5. Will the condition cause episodic flare-ups which prevent the employee from performing his/her job functions? ☐ **Yes** ☐ **No**

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

If yes, explain:
_____
_____

6. 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)

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: _____

Contact information of Health Care Provider: _____
(Address)
(Phone number) _____(Fax) _____(Email address)_____