UT Health San Antonio
Human Resources

Family and Medical Leave Act (FMLA)
Certification of Health Care Provider-
For an Employee Only

For Completion by Employee: This form must be completed in its entirety by your health care provider and returned to HR within 15 calendar days. Failure to provide a complete and sufficient medical certification may result in the delay or denial of your FMLA request. If your request for FMLA also includes work restrictions, contact your supervisor and HR to discuss alternate work options.

By submitting this form to your health care provider, you authorize that provider to release the completed form to the administrators of the Family and Medical Leave Act at the UT Health San Antonio.

1. UT Health SA Employee's Name: ______________________	2. Employee's EID: ______________________
3. Job Title: ______________________	4. Date: ______________________

For Completion by the Health Care Provider: 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 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 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

5. Describe relevant medical facts for patient in box 1 (such facts may include symptoms, diagnosis, or any regimen of continuing treatment)

☐ Please check if additional pages were added

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6. Date condition commenced:	7. Estimated duration of condition:	8. Is condition pregnancy? ◯ Yes ◯ No
______________________	◯ Lifetime ◯ Unknown ◯ Undetermined Approximate end date if possible: ______________	If yes, expected deliver date: ______________

9. FOR FMLA ELIGIBILITY Please check any applicable category or categories relating to the employee's medical condition:

a. ☐ Incapacity of More Than Three Calendar Days - This period of incapacity involves:
- treatment two or more times by a health care provider;
- treatment by a health care provider on at least one occasion with prescribed medication; and/or
- treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment (including prescriptions)

b. ☐ Pregnancy - Any period of incapacity due to pregnancy or prenatal care.

c. ☐ Hospital Care - inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility.

d. ☐ Intermittent Incapacity / Chronic Condition Requiring at Least Two Treatments per Year (i.e., migraine headaches, diabetes, asthma, etc)

e. ☐ Permanent/Long-term Condition Requiring Supervision - (i.e., Alzheimer's, severe stroke, terminal illness)

f. ☐ Multiple Treatment (Non-Chronic Conditions) - (i.e., physical therapy for severe arthritis or dialysis for kidney disease)

g. ☐ None of the Above.

10. AMOUNT OF LEAVE NEEDED Please check the following statements(s) that apply to the employee's medical condition resulting from the injury or illness, and answer the following questions based on the employee's job description or the employee's own description of his/her job functions:

a. ☐ The employee **may return to work without restrictions.** Return to work date: ______________________

b. ☐ The employee is incapacitated and may not return to work until: ______________ (date).

c. ☐ The employee **may return to work, but may miss work on an episodic basis as a result of flare-ups.** Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: ________ times per ◯ week ◯ month **Duration:** ________ ◯ hour(s) or ◯ day(s) per episode

d. ☐ The employee **may return to work with work restrictions indicated below.** Return to work date: ______________________

☐ A reduced work schedule is needed at ____ hours per day, ____ days per week from __________ (date) to __________ (date).

☐ The following work restrictions are recommended from __________ (date) through __________ (date).

☐ Check this box if the restrictions written in the space above are permanent.

Additional Information or Comments:

Health Care Provider SIGNATURE

Health Care Provider PRINTED Name

Date

Phone

Type of Practice/ Medical Specialty

Return completed form to:

UT Health San Antonio, Office of Human Resources
7703 Floyd Curl Drive, San Antonio, Texas 78229

Phone: (210)567-2600, option 5
Fax : (210)567-6791
E-mail: hr-leaveadmin@uthscsa.edu

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