UT Health San Antonio
Human Resources

Family and Medical Leave Act (FMLA)
Certification of Health Care Provider- Care for Family Member

For Completion by Employee: This form must be completed in its entirety by your family member's 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.

By submitting this form to his/her health care provider, you family member authorizes 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 & EID : _____

2. Patient(employee's family member): _____

3. Date: _____

4. Patient's relationship to UT Health SA employee:

◯ Child ◯ Spouse ◯ Parent ◯ Other _____ If child, also provide: ◯ Child's date of birth: _____

◯ Child over age 18 but regarded as disabled due to mental or physical condition. Consult with HR, (210)567-2600, option 5

5. Describe the care you will provide to your family member and estimate the leave needed to provide the care. You may use additional pages if necessary.

☐ Please check if additional pages were added

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.

6. Describe relevant medical facts for patient in box 2 (such facts may include symptoms, diagnosis, or any regimen of continuing treatment)

☐ Please check if additional pages were added

7. Date condition commenced:	8. Estimated duration of condition:	9. Is condition pregnancy? ◯ Yes ◯ No
_____	◯ Lifetime ◯ Unknown ◯ Undetermined Approximate end date if possible: _____	If yes, expected deliver date: _____

Revised December 21, 2018

10. FOR FMLA ELIGIBILITY Please check any applicable category or categories relating to the PATIENT referenced in box 2:

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.

11. Please check any applicable boxes regarding our employee's need to care for patient in box 2:

☐ Psychological Comfort ☐ Activities of Daily Living ☐ Transporation ☐ Medical Assistance ☐ Other _____

12. AMOUNT OF LEAVE NEEDED Please check the following statement(s) that apply to the patient's need for care from our employee:

a. ☐ The employee **is needed to care for the patient on a full-time basis** until re-evaluation on (date) _____

b. ☐ The employee **is needed to assist the patient in attending follow-up appointments** on (dates) _____

c. ☐ The employee **is needed to care for the patient on an intermittent/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 time the employee needs to take to care of the patient and/or (e.g. 1 episode every 3 months lasting 1-2 days):

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

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