

Please return completed form to:
 Idaho State University
 Office of Human Resources
 921 South 8th Ave., Stop 8107
 Pocatello, ID 83209-8107



Certification of Health Care Provider for Employee's or Family Member's Serious Health Condition (Family and Medical Leave Act)

| Section I – Employee Information (to be completed by Idaho State University) | | | |
|---|--|---|---------------------|
| Employee Name | | | |
| Employee's Job title | | Regular work schedule | |
| Employee's essential job functions | | Job description attached [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | |
| Patient's Name (if different from employee) | | | |
| Section II – Part A - Medical Facts (to be completed by Health Care Provider) | | | |
| Provider's Name | | | |
| Address | | City | State Zip Code |
| Telephone Number | | Fax Number | |
| Type of practice / Medical specialty | | | |
| Approximate date condition commenced | | Probable duration of condition | |
| Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | If so, dates of admission | |
| Date(s) you treated the patient for condition | | | |
| Will the patient need to have treatments visits at least twice per year due to the condition? [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | Was medication, other than over-the-counter medication prescribed? [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | |
| Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | If so, state the nature of such treatments and expected duration of treatment | |
| Is the medical condition a pregnancy? [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No | | If so, expected delivery date: | |
| <p>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.</p> <p>Is the employee unable to perform any of his/her job functions due to the condition: [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No</p> <p>If so, identify the job functions the employee is unable to perform:</p> | | | |

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 treatments such as the use of specialized equipment):

Section II – Part B – Amount of leave needed (to be completed by Health Care Provider)

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|---|--|
| Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No | If so, estimate the beginning and ending dates for the period of incapacity: |
|---|--|

| | |
|---|---|
| Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No | If so, are the treatments or reduced number of hours of work medically necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including recovery period:

Are treatment appointments available outside the employee's scheduled working hours? Yes No

Estimate the part-time or reduced work schedule the employee needs, if any:

Will the condition cause episodic flare-ups periodically preventing 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

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 that the patient may have over the next six months (e.g. 1 episode every 3 months last 1-2 days):

ADDITIONAL INFORMATION:

If leave is required to care for a family member with a serious health condition, complete the following:

| | |
|--|--|
| Does the patient require assistance for basic medical or personal needs or safety, or for transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No | If no, would the employee's presence to provide physiological comfort be beneficial to the patient or assist in the patient's recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

If the patient will need care only intermittently or on a part-time basis, indicate the probably duration and frequency of this need:

Signature of Health Care Provider

Date

Section III –Leave is needed to care for a family member (to be completed by employee)

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date