AG-521 (04/22/2020)
Texas A&M AgriLife
Administrative Services – Human Resources

Medical Certification Form for EMPLOYEE

*The employee must have this form **completed by a licensed health care provider** and should provide this information to his/her department for the purposes of sick leave usage, sick pool eligibility and Family and Medical Leave Act (FMLA) eligibility.*

TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER ONLY

Instructions to the Health Care Provider: Our employee has indicated a need for leave under the FMLA. Please answer fully and completely ALL applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Failure to provide sufficient information may cause the employee's FMLA request to be delayed or denied.

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.

Employee's Name (Print):	
Approximate date condition began:	**Estimated duration:** ☐ **Lifetime** ☐ **Unknown** ☐ **Ending Date, if known:**
Describe medical facts, symptoms, diagnosis or any regimen of continuing treatment:	

PART A: FMLA ELIGIBILITY – Mark appropriate category or categories relating to employee's medical condition:

☐ **Hospital Care** –Overnight stay in a hospital, hospice, or residential medical care facility on: _____

☐ **Incapacity of More Than Three Consecutive Calendar Days –** Involves treatment by a health care provider:
- Two or more times
- At least one occasion with prescribed medications
- At least one occasion that resulted in regimen of continuing treatment

☐ **Pregnancy** – Incapacity due to pregnancy or for prenatal care: **Expected delivery date:** _____

☐ **Intermittent Incapacity/Chronic Conditions Requiring at least Two Treatments by a Health Care Provider**
- Requires periodic visits for treatment
- Continues over an extended period of time
- May cause episodic rather than continuing periods of incapacity (Examples: asthma, migraine headaches, diabetes, etc.)

☐ **Permanent/Long-term Conditions Requiring Supervision** – Due to a condition where treatment may not be effective. Under continuing supervision of, but need not be receiving active treatment. (Examples: Alzheimer's, severe stroke, terminal stages of illness, etc.)

☐ **Multiple Treatments (Non-Chronic Conditions)** – Any period of absence to receive multiple treatments by a health care provider (Examples: physical therapy for severe arthritis or dialysis for kidney disease, etc.)

☐ **None of the Above**

PART B: LEAVE NEEDED – As a result of employee's medical condition, the employee:

☐ **Will be incapacitated for a single continuous period of time:** From: _____ to: _____

☐ **May return to work without restrictions on:** _____

☐ **May not return to work until further evaluation on:** _____

☐ **May return to work with restrictions:** From: _____ to: _____

The following work restrictions are recommended: _____

☐ **May return to work Part-time:** ____hours per day ____days per week From: _____ to: _____

☐ **May return to work, but may need to attend follow-up appointments, treatments, physical therapy, etc.**

Date(s) or estimated date(s) of appointments: _____

☐ **May return to work, but may miss work due to periodic flare-ups that prevent employee from performing his/her job functions.**

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. an episode every 3 months lasting 1-2 days):

Frequency: _____times per week ____times per month **Duration:** ____hours or_____day(s) per episode

☐ **Identify the job duties the employee is unable to perform:** _____

_____ **Check to confirm receipt/review of the Employee's position description:** ☐

_____ _____
Health Care Provider's Signature **Date**

_____ _____
Health Care Provider's Printed Name **Type of Practice/Medical Specialty**

Telephone Number: _____ **Fax Number:** _____

EMPLOYEE – SUBMIT FORM TO:
Your Department's Leave Administrator
or Appropriate Designee
CONTACT INFORMATION:
AgriLife Human Resources
(979) 845-2423 Phone
(979) 458-1046 Fax