

A complete medical certification is required to determine whether your health condition or the health condition of your spouse, child, or parent qualifies for leave under the Family and Medical Leave Act.

**Instructions to Employee:** Complete Sections 1 and 2. If you are requesting leave to care for your spouse, son, daughter, or parent who has a serious health condition, also complete section 3. Your health care provider or your family member’s health care provider must complete Sections 4 through 10. It is your responsibility to ensure that the health care provider completes this form and returns it to the appropriate address within 15 calendar days.

**Instructions to Health Care Provider:** Your patient or a family member of your patient has requested leave under the Family and Medical Leave Act (FMLA). In order for us to verify this leave qualifies under the FMLA, please complete Sections 4 through 10 of this form, and return it within 15 calendar days of receipt to the contact listed below:

Send completed certification to: University of Tennessee Space Institute (UTSI)  
Human Resources  
411 B. H. Goethert Parkwy  
Tullahoma, TN 37388-9700  
ph: 931-393-7226  
fax: 931-393-7268

**Employee: Complete Sections 1, 2, and 3**

**Section 1 – Patient Information (Printed)**

Employee’s Name: \_\_\_\_\_

Patient’s Name: \_\_\_\_\_

Relationship to Employee (if son or daughter, list date of birth): \_\_\_\_\_

**Section 2 – Employee Signature**

I permit the UTSI Human Resources, or its designated health care provider or third party administrator, to contact my health care provider or my family member’s health care provider for purposes of obtaining clarifying information and authenticity of this medical certification, if necessary.

\_\_\_\_\_  
Employee Signature \_\_\_\_\_  
Date

**Section 3 – Care for Family Member (Printed)**

State the care you will provide for your family member (if applicable).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health Care Provider: Complete Sections 4 through 10**

**Section 4 – Patient Information (Printed)**

Employee’s Name: \_\_\_\_\_

Patient’s Name: \_\_\_\_\_

Relationship to Employee (check one):

- Self                       Child
- Spouse                     Parent

**Section 5 – Designation of Serious Health Condition**

Under FMLA a “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves one or more of the categories below. Does the patient’s condition for which he/she is requesting FMLA leave qualify under any of the categories described? (Check all that apply.)

[Detailed definition of serious health condition is listed on P. 4.]

- Inpatient Care (Overnight stay in hospital, hospice, or residential medical care facility)  
List dates of admission: \_\_\_\_\_
- Continuing Treatment (Patient is unable to work or perform other regular daily activities for more than three consecutive, full calendar days and needs treatment.)
- Pregnancy  
List estimated date of delivery: \_\_\_\_\_
- Chronic Serious Health Condition (i.e., asthma, diabetes, epilepsy, etc.)
- Permanent/Long-term Condition Requiring Supervision (i.e., Alzheimer’s, severe stroke, terminal stages of disease)
- Multiple Treatments (i.e., for cancer, severe arthritis, kidney disease, etc.)
- Not a serious health condition (proceed to Section 9)

Describe the patient’s medical condition and provide any supporting medical facts for this certification (attach additional page if necessary):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provide the dates you treated the patient for this condition: \_\_\_\_\_

**Section 6 – Duration of Incapacity and Treatments**

State the approximate date the condition commenced: \_\_\_\_\_

Estimate the probable duration of condition: \_\_\_\_\_ to \_\_\_\_\_

Nature and estimated duration of treatment prescribed:

\_\_\_\_\_

\_\_\_\_\_

**Health Care Provider: Complete Sections 4 through 10**

**Section 7 – Employee Work Status (Self Condition)**

Complete section 7 only when employee needs to take leave due to employee’s own serious health condition. Please provide specific information (i.e. 2 hours per day, twice per week for therapy, appointments, etc).

Because of the condition identified in section 5, it is medically necessary for the employee to:

- Take FML on consecutive days from \_\_\_\_\_ to \_\_\_\_\_
- Take intermittent leave according to the following schedule: \_\_\_\_\_  
\_\_\_\_\_
- Work a reduced schedule according to the following: \_\_\_\_\_  
\_\_\_\_\_

Will the condition cause episodic flare-ups periodically, preventing the employee from performing his/her job functions? \_\_\_No \_\_\_Yes

Is it medically necessary for the employee to be absent from work during flare-ups? \_\_\_ No \_\_\_Yes If yes, explain:

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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 6 months (i.e. 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) month(s) \_\_\_\_\_

Duration: \_\_\_\_\_ hours or \_\_\_ day(s) per episode

**Section 8 – Employee Work Status (To Care for Family Member)**

Complete section 8 only when employee needs to take leave to care for patient who is a family member with a serious health condition. Please provide specific information (i.e. 2 hours per day, twice per week for therapy appointments, etc).

Because of the condition identified in section 5, the employee needs a leave of absence to (select all that apply):

- Assist patient with basic medical needs, hygiene/nutritional needs or for safety or transportation purposes.
- Provide psychological comfort that would be beneficial to patient or assist in patient’s recovery.

Identify the duration and estimated schedule of time needed by employee to care for patient:

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## Health Care Provider: Complete Sections 4 through 10

### Section 9 – GINA Information

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) prohibits employers 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.

### Section 10 – Health Care Provider Information

Name of Health Care Provider (Print): \_\_\_\_\_  
Type of Practice: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

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**Signature of Health Care Provider**

**Date**

#### A Serious Health Condition Defined:

For FMLA purposes, a “serious health condition” is an illness, injury, impairment or physical or mental condition that involves:

- a. Any inpatient care (an overnight stay) in a hospital, hospice, or residential care facility, including any period of incapacity or any subsequent treatment in connection with such inpatient care;
- b. Continuing treatment by a health care provider that results in a period of incapacity of more than three consecutive, full calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves (i) treatment by or under the direction of a health care provider on two or more occasions within 30 days of the first day of incapacity, absent extenuating circumstances, or (ii) treatment at least once by a health care provider which results in a regimen of continuing treatment. The employee must have an in-person visit to the health-care provider within seven days of the first day of incapacity;
- c. Any period of incapacity due to pregnancy or for prenatal care;
- d. Any period of incapacity or treatment due to a chronic serious health condition. A chronic serious health condition is one that (i) requires visits to a health care provider at least twice a year, (ii) that continues over an extended period of time (including recurring episodes of the condition), and (iii) may cause episodic periods of incapacity (*e.g.*, asthma, diabetes, epilepsy)
- e. A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective (*e.g.*, Alzheimer’s, stroke terminal diseases), provided that the employee or family member is under the continuing supervision of a health care provider;
- f. Any period of absence to receive multiple treatments (including recovery) by a health care provider for restorative surgery or for conditions that would likely result in incapacity in the absence of treatment (*e.g.*, chemotherapy, dialysis).