



CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE

SECTION I: INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your medical provider.

Employee's Full Name: \_\_\_\_\_ myWSU ID # \_\_\_\_\_
Employee's Job Title: \_\_\_\_\_ Regular Work Schedule: \_\_\_\_\_
Employee's Essential Job Functions: \_\_\_\_\_

Position Description is Attached: [ ] Yes [ ] No

SECTION II: INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave. Answer fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon 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 leave coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's Name: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

MEDICAL FACTS

Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? [ ] No [ ] Yes If yes, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

Will the patient need to have treatment visits at least twice per year due to the condition? [ ] No [ ] Yes

Was medication, other than over-the-counter medication, prescribed? [ ] No [ ] Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? [ ] No [ ] Yes If yes, state the nature of such treatments and expected duration of treatment: \_\_\_\_\_

Is the medical condition pregnancy? [ ] No [ ] Yes If yes, expected delivery date: \_\_\_\_\_

Use the information provided by the employee in Section I to answer this question. If the employee fails to provide a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: [ ] No [ ] Yes

If yes, identify the job functions the employee is unable to perform: \_\_\_\_\_

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 treatment such as the use of specialized equipment):

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**AMOUNT OF LEAVE NEEDED**

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  No  Yes

If yes, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_ to \_\_\_\_\_

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?  No  Yes

If yes, are the treatments or the reduced number of hours of work medically necessary?  No  Yes

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

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

\_\_\_\_\_ hour(s) per day \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

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 the 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 (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s). Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode.

**Additional Information - Identify Question with Your Additional Answer:**

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Signature of Health Care Provider

Date

\* "Incapacity," for purposes of medical leave, is defined to mean inability to work, attend school or perform other regular activities due to the serious health condition, treatment therefore, or recovery therefrom.

\*Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

\* A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic), or therapy requiring special equipment to resolve or alleviate the health conditions. A regimen of treatment does not include the taking of over-the-counter medications such as Aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

**Paperwork Reduction Act Notice and Public Burden Statement**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT OR TO WICHITA STATE UNIVERSITY HUMAN RESOURCES.**