TARLETON STATE UNIVERSITY
Member of The Texas A&M University System

EMPLOYEE'S CONDITION
Certification of Health Care Provider Form

Employee Instructions : This form must be completed by a practitioner regarding the employee's health condition. The employee 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.

Physician's Instructions : 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.

1. Tarleton State University Employee Name

2. Date

3. Medical facts, symptoms, diagnosis of condition:

4. Is condition pregnancy? Yes No

If yes, expected delivery date:____________

5. Approximate date condition commenced:

6. Probable duration of condition: Lifetime Unknown or Undetermined

Other (#days/weeks etc)______________________ Ending Date, if known ______________

7. FOR FMLA ELIGIBILITY: Please check any applicable category or categories relating to the employee's medical condition:

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 for 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 Conditions Requiring at Least Two Treatments Per Year**
- May cause episodic rather than continuing periods of incapacity
- Examples: migraine headaches, diabetes, fibromyalgia

e. **Permanent/Long-term Conditions Requiring Supervision** – Examples: Alzheimer's, severe stroke, terminal illness

f. **Multiple Treatments (Non-Chronic Conditions)** – Examples: physical therapy for severe arthritis or dialysis for kidney disease

g. **None of the Above.**

8. AMOUNT OF LEAVE NEEDED: Please check the following statement(s) that apply to the employee's medical condition resulting from the injury or illness, and answer the following questions <u>based on the employee's attached job description</u> or the employee's own description of his/her job duties:

a. The employee **may return to work without restrictions.** Return to work date: ______________________________.

b. The employee **may not return to work until further evaluation** on _______________________________ (date).

c. The employee **may return to work, but may miss work on an 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 related incapacity the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: ________ times per week month **Duration:** ________ hour(s) or day(s) per episode.

d. The employee **may return to work with restrictions.**

A part-time or reduced work schedule is needed at ___ hours per day, ___ days per week from _________(date) through _________(date).

The following work restrictions are recommended (additional information may be provided in box 10):

9. FOLLOW-UP APPOINTMENTS, REGIMEN OF TREATMENT, ETC.:

a. Will the employee need to attend follow-up treatment appointments (physical therapy, etc.) because of his/her medical condition? Yes No

b. If Yes, please provide the date(s) of the scheduled appointments. If date(s) are not firm, please estimate:

10. PHYSICIAN: Describe other relevant medical facts related to the items above for which the employee seeks medical leave (treatment, restrictions, etc); you may add additional pages, if necessary. Please check if you have attached additional statements or information

X____

PRACTITIONER SIGNATURE

____

Practitioner PRINTED Name

SUBMIT FORM TO
Employee Services
Box T-0510, Stephenville, TX 76402
OR Fax To: 254-968-9590

NEED HELP?
Employee Services
(254) 968-9128
benefits@tarleton.edu

Date **Phone**

Type of Practice / Medical Specialty