FAMILY MEMBER'S CONDITION
Certification of Health Care Provider Form

Employee Instructions : This form must be completed by a practitioner for the employee's family member'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 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. Please provide medical history information regarding your patient only to the extent necessary to fully respond to all relevant items below

1. Tarleton State University Employee Name	**2. Patient (employee's family member)**	**3. Date**
4. Patient's relationship to Tarleton State employee: ☐ Child ☐ Spouse ☐ Parent ☐ Other_____ If child, list child's date of birth: _____	**5. Medical facts, symptoms, or diagnosis of patient's condition (more space box 14):**	
6. Approximate date condition commenced:	**7. Estimated duration of condition:** ☐ Lifetime ☐ Unknown ☐ Undetermined ☐ Other (list approximate end date if possible): _____	**8. Is condition pregnancy?** ☐ Yes ☐ No If yes, expected delivery date:_____

9. FOR FMLA ELIGIBILITY Please check any applicable category or categories relating to the PATIENT referenced in box 2:

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** (i.e., migraine headaches, diabetes, fibromyalgia)

e. ☐ **Permanent/Long-term Conditions Requiring Supervision** – (i.e., Alzheimer's, severe stroke, terminal illness)

f. ☐ **Multiple Treatments (Non-Chronic Conditions)** – (i.e., physical therapy for severe arthritis or dialysis for kidney disease)

g. ☐ **None of the Above.**

10. PRACTITIONER Please check any applicable boxes regarding our employee's need to care for patient in box 2; more room in box 14:

☐ Psychological Comfort ☐ Safety ☐ Transportation ☐ Medical Care and Hygiene ☐ Other _____

11. AMOUNT OF LEAVE NEEDED Please check the following statement(s) that apply to the patient's need for the employee's care resulting from the injury or illness:

a. ☐ The employee **may return to work,** as the patient no longer requires care. Return to work date: _____.

b. ☐ The employee **may not return to work and is needed to care for the patient on a full-time basis** until reevaluation _____(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.

12. FOLLOW-UP APPOINTMENTS, REGIMEN OF TREATMENT, ETC. FOR PATIENT IN BOX 2; additional room available in box 14:

a. Will the employee be needed to assist the patient to attend follow-up treatment appointments 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:

13. EMPLOYEE: Describe the care you will provide to your family member and estimate the leave needed to provide the care. You may use additional pages if necessary. ☐ **Please check if additional statements are attached to this form.**

14. PRACTITIONER: You may provide additional information here and use additional pages. ☐ **Please check if additional pages were added.**

X_____
PRACTITIONER SIGNATURE

_____
Practitioner PRINTED Name

_____ _____
Date **Phone**

_____
Type of Practice / Medical Specialty

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