

The Texas A&M University System Medical Certification Form

HR 36 (11/02)

With few exceptions, you have the right to request, receive, review and correct information about yourself collected using this form.

All sections except the last (Care of a Family Member) must be completed by the employee's or family member's health care provider.

1. Employee's name

2. Patient's name (if different from employee)

3. Date incapacity¹ commenced

4. Date treatment first received (sick leave pool applicants only)

Employee or Family Member *Please complete the following questions regardless of whether the patient is an employee or a member of an employee's family.*

5. The attached sheet (Serious Health Condition) describes what is meant by a "serious health condition." Please check the appropriate category listed on that sheet that describes the patient's condition².

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ None of these apply _____

6. Describe the medical facts supporting your certification, including a brief statement as to how this serious health condition meets the criteria of the category checked above.

7. As a result of the condition or due to treatment, the employee will need to (check one):

a. Be absent from work until _____ (probable return date)

b. Work intermittently. Describe schedule: _____

c. Work part time. Describe schedule: _____

_____ until _____
_____ (probable date of return to regular work schedule)

8. If the condition is chronic or a pregnancy, state whether the patient is presently incapacitated and the duration or frequency of episodes of incapacity.

9. If additional treatments will be required for this condition, provide an estimate of the number of treatments, and if the patient will be absent from work or other daily activities intermittently or part time due to the treatments, describe the probable number and intervals between these treatments, actual dates of the treatments, if known, and any period of recovery.

10. If any of these treatments will be provided by another provider of health services (for example, a physical therapist), please state the nature of treatments.

11. If a regimen of continuing treatment is required under your supervision, provide a general description of such treatment (for example, prescription drugs, physical therapy requiring special equipment).

Employee *Please complete this section only if the employee is the patient.*

12. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?
Yes _____ No _____
13. If the employee is able to perform some work, what essential functions of the employee's job is the employee able to perform? (The employee or the employer can provide a list of essential job functions.)
14. If neither of the above applies, is it necessary for the employee to be absent from work for treatment?
Yes _____ No _____

Family Member *Please complete this section only if the patient is a member of the employee's family.*

15. If this leave is required to care for an employee's family member who has a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?
Yes _____ No _____
16. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?
Yes _____ No _____
17. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need.

Health Care Provider's Signature *Health care providers must complete this section regardless of whether the patient is an employee or a member of an employee's family.*

Health care provider's signature

Address

Health care provider's printed name

Type of practice

Date

Telephone number

Care of a Family Member *The following is to be completed by the employee needing family leave to care for a family member.*

18. State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if you will need to work a part-time schedule.

Employee's signature

Date

¹ "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery therefrom.

² Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

Serious Health Condition

A serious health condition is an illness, injury, impairment or physical or mental condition that involves one of the following:

1. **Hospital Care**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:

- (1) Treatment¹ two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- (2) Treatment by a health care provider on at least one occasion that results in a regimen of continuing treatment² under the supervision of the health care provider.

3. **Pregnancy**

Any period of incapacity due to pregnancy, or for prenatal care.

4. **Chronic Conditions Requiring Treatments**

A chronic condition that:

- (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
- (2) Continues over an extended period (including recurring episodes of a single underlying condition); and
- (3) May cause episodic periods rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. **Permanent/Long-Term Conditions Requiring Supervision**

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy) or kidney disease (dialysis).

¹ 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.

² 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 condition. 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.