Certification of Health Care Provider for Serious Health Condition (FMLA) – Duke Family Member (Form 1002-F)

Employee Statement

_____ _____ _____ _____ _____

First Name | Last Name | Duke Unique ID | Best Phone No. | Shift (Days/Nights/Weekends)

_____ _____ _____ _____

Supervisor Name | Telephone No. | E-mail | Fax No.

Name of Family Member

_____ _____ _____ _____

First Name | Middle Name | Last Name | DOB

Relationship of family member to you: ☐ Spouse ☐ Parent ☐ Son or daughter ☐ Duke registered same sex spouse equivalent

Describe care you must provide to your family member and estimate leave time needed to provide care:

_____

_____

Family Member Authorization: *I authorize **Employee Occupational Health & Wellness**, or its representative, to contact the health care provider indicated on this form for clarification or authentication of any of the information below. I also authorize my health care provider to disclose the health information described in this Certification for the purpose of clarification. I understand that I can revoke the above authorization at any time by submitting a written request.*

_____ _____

Signature of Family Member | Date

Health Care Provider Statement

The above employee has requested leave to care for a family member under the FMLA. Please answer fully all applicable questions below and limit your responses to the condition for which your patient needs care by our employee. Please be as specific as possible.

_____ _____

Health Care Provider's Name *(Please Print)* | Type of Practice

_____ _____ _____

Telephone No. | E-mail | Fax No.

GINA NOTICE: *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 result of an individual's or family member's genetic test, 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.*

Medical Facts

1. Is the medical condition pregnancy? ☐ Yes ☐ No

   If yes, expected delivery date _____

2. Approximate date this medical condition began _____ Probable duration of condition _____

3. Was your patient admitted for an overnight stay in a hospital, hospice or residential care facility? ☐ Yes ☐ No

   If yes: Date of admission _____ Date of discharge _____

4. Please list the three most recent date(s) you have treated your patient for this condition: _____

5. Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

6. Will your patient need treatment visits at least twice per year due to this condition? ☐ Yes ☐ No

7. Was your patient referred to other health care provider(s) for evaluation and/or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If yes, state the nature and expected duration:_____

   _____

8. Please describe other relevant medical facts related to the condition for which your patient needs leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment).

   _____

   _____

Amount of Care Needed

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

9. Will your patient be incapacitated for a single continuous period of time, including time for treatment and/or recovery? ☐ Yes ☐ No

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

   Begin date _____ End date _____

10. During this time, will your patient need continuous care by a family member? ☐ Yes ☐ No

    If yes, explain the care needed by your patient and why such care is ***medically necessary***:_____

    _____

    _____

11. Will your patient require follow-up treatments or other intermittent care, including any time for recovery requiring care by a family member? ☐ Yes ☐ No

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

    _____

    Explain the care needed by your patient and why such care is medically necessary (if not explained above):_____

    _____

    _____

    Estimate the hours your patient needs care from a family member on an intermittent basis, if any:
    ____ hour(s) per day; ____ day(s) per week from _____ through _____

    Are these hours required at a specific time of the day? ☐ Yes ☐ No
    If yes, please specify:_____

    _____

12. Will the condition cause episodic flare-ups requiring care of your patient by a family member? ☐ Yes ☐ No

    Based upon your patient's medical history and your knowledge of the medical condition, estimate the amount of medical leave necessary for a family member to provide care to your patient for flare-ups, including the frequency and the duration of related incapacity that your patient may have over the next 6 months (*e.g.,* 1 episode every 3 months, lasting 1-2 days).**

    ****While it may be difficult to answer this question precisely, please give your best estimate of the frequency and duration of the flare-ups. If this information is not provided, the default frequency will be 4 times per year for 1 day.**

    Frequency: ____ times per ____ week(s) _____ month(s)

    Duration per episode: ____ hour(s) or ____ day(s)

Explain the care needed by your patient and why such care is ***medically necessary***:_____
_____
_____

Additional information related to question(s) above (please indicate question number):_____
_____
_____

_____ _____
Health Care Provider Signature Date

Health Care Provider: Return completed form to employee