Clemson University Family Medical Leave Act (FMLA) Medical Certification Form

(To be completed by health care provider and submitted via eFax to 864.780.5844)

Note to employee: Family medical leave is governed by the Dept. of Labor's Family Medical Leave Act of 1993. Have your health care provider complete this form and submit it using the mailing directions below. Applicants must submit the Family Medical Leave Request Form through Workday. Faculty and staff are encouraged to provide their health care provider with a copy of their current position description, which can be obtained from their HR Service Manager.

Note to healthcare provider: "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 ask 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.

Employee Name: _____

Patient Name (If other than the employee): _____

Name of Health Care Provider: _____

Name and Type of Practice: _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Telephone Number:** _____

Date Condition Began: _____ **Expected Duration/End Date:** _____

If FMLA is for illness of the employee, is the employee able to perform essential job functions?

☐ Yes ☐ No ☐ FMLA is not for illness of employee

If FMLA is for the care of a seriously ill family member, does the family member need assistance with basic care?

☐ Yes ☐ No ☐ FMLA is not for the care of a seriously ill family member

Is inpatient hospitalization of the patient required? ☐ Yes ☐ No **Begin date:** _____

State reason for FMLA and the nature of care the patient requires (e.g., dependent child born premature; requires 6 weeks additional in-home, ongoing care):

Is the reason for FMLA and the care the patient requires medically necessary? ☐ Yes ☐ No

The patient/caregiver needs FMLA (select one):

☐ For a single continuous period of time (full-time)

☐ On a part-time or reduced schedule (intermittent)

If you selected "part-time or reduced schedule (intermittent)" above, please estimate the treatment schedule or reduced work schedule, including dates and times, reduction of hours, etc.:

Signature of Health Care Provider: _____

Date: _____

The Office of Human Resources reserves the right to verify the information provided on this document, including, but not limited to the patient's medical condition, beginning and ending dates, and the physician's signature.