# Certification of Health Care Provider for Serious Health Condition (FMLA) – Duke Employee (Form 1002-E)

## Employee Statement

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

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

*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.*

Employee Signature _____ Date _____

## Health Care Provider Statement

The above employee has requested leave under the FMLA. Please answer fully all applicable questions below and limit your responses to the condition for which the employee needs leave. 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 the employee 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 the employee for this condition _____

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

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

7. Was the employee 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 the employee needs leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment).

_____

_____

## Amount of Leave Needed

9. Is the employee unable to perform any of his/her job functions* due to his/her condition? ☐ Yes ☐ No
   ***Answer after reviewing statement of the employee's job functions or, if not provided, after discussing with the employee**
   **If yes,** identify the job functions the employee is **unable** to perform: _____

   _____

   Indicate whether inability is: ☐ continuous or ☐ episodic

10. Was the employee or will the employee 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 ___/___/____ Date employee can return to work ___/___/____

11. Is it ***medically necessary*** for the employee to have follow-up treatments/appointments for this condition? ☐ Yes ☐ No

    **If yes,** estimate the treatment schedule:_____

12. Is it ***medically necessary*** for the employee to work part-time or on a reduced schedule because of this condition? ☐ Yes ☐ No

    **If yes,** estimate part-time/reduced schedule:
    ____ hour(s) per day; ____ day(s) per week from ___/___/____ through ___/___/____

13. Will the condition cause episodic flare-ups preventing the employee from performing his/her job functions? ☐ Yes ☐ No

14. Is it ***medically necessary*** for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

    **If yes,** please explain:_____

    _____

15. Are there job modifications that could be implemented during flare-ups to allow the employee to remain at work? ☐ Yes ☐ No

    **If yes,** please list:_____

    _____

16. Based upon the employee's medical history and your knowledge of the medical condition, please estimate ***both*** the frequency of flare-ups and the duration of related incapacity that the employee 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)

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

_____

_____

_____ _____

Health Care Provider Signature Date

**Health Care Provider: Return completed form to employee**