Certification of Healthcare Provider for Serious Condition

Type of Leave: Please check the box that best describes your leave. Updated version 8/20/26

☐ **Employee** (Self)

DOB: _____
Blazer ID:

☐ **Family Member-(Relationship)**
CHECK ONE: ☐ Spouse ☐ Parent
☐ Child under age 19 ☐ Child 19 or older incapable of self-care because of mental or physical
Name of family member: _____
_____ **DOB:**_____

Section I: Instructions: Employee to Complete or Employee's department. FMLA provides that an employer may require an employee seeking FMLA protection because of need for leave due to serious health condition(s) to submit a medical certification issued by the employee's health care provider. **Employee**: It is your responsibility to ensure that the health care provider returns the completed form to you or Employee Health/HR representative within 15 calendar days of receipt. Email documentation to medleavedocs@uabmc.edu or fax to 205-975-6900.

Employee Full Legal Name: _____
Other Known Names Used: _____ Blazer ID: _____
Employee Job Title: _____ Department: _____
Work Schedule: _____ Shift: _____
Work Email: _____ Secondary Email: _____
Phone number: _____ Cell: _____
Supervisor/Manager Name: _____ Phone/email #: _____

Section II: Limited Authorization for Release of Medical Information
I authorize the Healthcare Provider identified in Section III below to disclose to authorized representatives of UAB Hospital Employee Health and [UAB Medicine/Campus] only the medical information necessary to certify my eligibility for leave under the FMLA, including confirmation of a serious health condition; functional limitations related to job duties; and duration and timing of medically necessary leave. This authorization does NOT permit disclosure of the following: diagnosis details beyond what is required for FMLA certification; my complete medical record; genetic information; and information unrelated to FMLA leave. This authorization is voluntary and will expire upon the earliest of completion of the FMLA certification process, or one (1) year from the date signed below. I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it.

Accept ☐ **Decline** ☐
Employee Name: _____
Employee Signature: _____
Date: _____

Certification of Healthcare Provider for Serious Health Condition Cont.

Section III: For **Completion by Health Care Provider ONLY**- Your patient/family member of a patient has requested leave under FMLA. Answer fully **sections III through VI** and complete all applicable parts.

Provider Name: _____**Credentials:** _____
Medical Specialty: _____
Contact Email: _____Phone: _____
Business Address: _____ Fax: _____

Section IV: **Does the Employee or Employee Family Member have a serious health condition?**

☐ **YES** ☐ **NO**

A serious health condition means an illness, injury, impairment or physical or mental condition that involves one or more of the categories below. If yes, **please check the applicable category (ies)**. Please sign and date the document on page 3.

Section IV continued… (Healthcare provider completes) **PLEASE CHECK ALL THAT APPLY:**

☐ **Hospital Care** (inpatient) Date of Admission: _____

☐ **Absence plus treatment for incapacity** (patient is unable to work or perform other than regular daily activities for more than three (3) consecutive calendar days and needs ongoing treatment with follow-up visit/s.)

☐ **Pregnancy-Expected Due Date:** _____

If having a planned cesarean section (c-sec) place date her_____

☐ **Chronic Condition Requiring Treatment** (i.e., Asthma, Diabetes, Epilepsy, etc.)

☐ **Permanent/Long Term Condition Requiring supervision** (Alzheimer's, severe stroke, terminal stages of disease etc.)

☐ **Conditions requiring Multiple Treatments**: (e.g., chemotherapy treatments, restorative surgery).

Approx. date condition commenced: _____ Probable duration of condition: _____

Was the patient referred to other health care providers for evaluation or treatment (i.e., physical therapist)?

☐ Yes - Providers Name and Specialty _____ ☐ No

Complete if Applicable: If leave is requested for planned treatment, is the treatment medically necessary for the serious health condition identified above? ☐ Yes ☐ No

Describe the medical facts supporting the above certifications:

_____
_____
_____
_____
_____
_____

Section V (healthcare provider completes)
Will the employee be subject to ongoing medical treatment for the serious health condition identified above?

☐ **Yes** or ☐ **No**

Estimate treatment schedule, if any, including dates of any scheduled appointments and the time required for each appointment. Including and recovery period:

_____
_____

Certification of Healthcare Provider for Serious Health Condition Cont. Section V cont. (Healthcare Provider completes)

Check off all that apply:

☐ for appointments ☐ for flare-ups ☐ for ongoing Treatments

☐ Assist patient's basic medical needs, hygiene, nutritional needs, or safety and transportation purposes

☐ Provide psychological comfort that would be beneficial to the patient or assist in patients' recovery

USE ONLY FOR A REDUCED SCHEDULE- please indicate work hours reduced to**:**

Hours per day _____ ~OR~ Working only: _____ days per week

Other: _____

Section V cont.: For Employee and/or for the Employee's Family Member with a serious health condition. Because of the (employee/family member) condition, described on page two, it is necessary for the **employee** to take leave below: Please check and fill out. **(Healthcare provider completes)**

☐ **Take a Continuous leave** of absence on consecutive days:

Start Date _____ **Expected End Date**_____

FOR EXTENSION REQUEST ONLY: If an extension of the employee leave is medically indicated, is the anticipated date for end of leave, a reasonable estimated date by which the employee is expected to be able to resume their regular work duties, with or without reasonable work accommodation? ☐ YES ☐ NO

If accommodation(s) are anticipated, what would it/they be and for approx. how long?

_____

_____

~OR~

☐ **Take Intermittent leave** according to the following schedule or reduced schedule of hours per day or days per week: Please check off and fill out how often and for how long this may be. (For example, only...2 x monthly for 2hrs.-12 hrs. or 1 day).

Start Date: _____ **End Date:** _____

Frequency: ☐ **1x** ☐ **2x** ☐ **3x** times **per week** ~OR~ other #_____ x per week

~ OR~

☐ **1x** ☐ **2x** ☐ **3x monthly** ~OR~ _____x **monthly** Other Frequency: state below

_____

_____

Duration: _____**hours** or _____ **day(s**) or OTHER-_____

PLEASE MAKE SURE ALL SECTIONS ARE COMPLETED BEFORE SUBMITTED

Section VI: Signature Healthcare Provider and date:

Signature:

_____**Date:** _____