KEAN
OFFICE OF HUMAN RESOURCES

Serious Health Condition - Medical Certification

IN RESPONSE TO A MEDICAL LEAVE OF ABSENCE REQUEST

To be completed by your Health Care Provider

Employee Name: _____ Title/Dept: _____

Email: _____ Mobile: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking leave pursuant to the Family Medical Leave Act (FMLA). Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient.

Why is the employee unable to perform their job duties? Describe appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave sufficient to verify the serious health condition. This should include a diagnosis, description of symptoms and required treatment (e.g., use of nebulizer, dialysis) for the serious health condition.

_____

_____

_____

_____

_____

_____

State the approximate date the condition started or will start: _____

Anticipated Recovery Date*: _____

**If date is not available, please indicate:*

- ❑ Your best estimate of how long the condition lasted or will last: _____

- ❑ Return to work date is undetermined
- ❑ Employee is permanently unable to work

Is this condition temporary or permanent?

- ☐ Temporary
- ☐ Permanent

Which of the following apply to the patients' serious health condition? Please check all that apply; This includes mental health.

- ☐ Requires or did require inpatient care
- ☐ Requires continuing treatment by a health care provider, as follows:
- ☐ Has incapacitated or will incapacitate the patient for more than three consecutive full calendar days, AND
  - o Requires two or more medical visits within 30 days, OR
  - o Requires one medical visit, plus a regimen of care.
- ☐ Incapacity due to pregnancy and/or pregnancy related conditions.
- ☐ Is chronic, requires treatments at least twice a year, and may require periodic absences
- ☐ Is long-term and requires ongoing medical supervision, with or without active treatment
- ☐ Requires multiple treatments and would lead to a period of incapacity without treatment
- ☐ Danger of death or terminal prognosis: The condition poses an imminent danger of death or is terminal in prognosis
- ☐ None of these

Due to the condition, the patient:

- ❑ (had / will have) planned medical treatment(s) (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s): _____

☐ (was/will be) referred to other health care provider(s) for evaluation or treatment(s). State the nature of such treatments: (e.g. cardiologist, physical therapy). _____.
Provide your best estimate of the dates _____ _____ for the treatment(s).

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

☐ Due to the condition, the patient (for treatment(s) and/or recovery was / will be) incapacitated for a **continuous period of time.**

- First date the employee was unable to work due to current medical condition necessitating a leave of absence: _____
- Anticipated recovery date: _____

☐ Due to the condition, it is medically necessary for the employee to **work a reduced schedule and be placed on a reduced schedule leave of absence**. Provide your best estimate of the reduced schedule the employee is able to work. From _____ to _____ the employee is **unable to work**: (e.g., 1 day per week)
_____.

☐ Due to the condition, it (was / is / will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last. Over the next 6 months, from _____ to _____, episodes of incapacity are estimated to occur -

Frequency: _____ times per _____ week OR
_____ times per _____ month

Duration: _____ hours per _____ episode OR
_____ days per _____ episode

Is there a possibility that the employee could work if accommodations were provided other than leave? If yes, do you have suggestions regarding those possible accommodations? How would your suggestions improve the employee's job performance?

By signing below, I certify that this information is true and accurate to the best of my knowledge.

Health Care Provider Signature	Print Name	Date
Specialty	Address	State/Zip

NOTE TO PHYSICIAN: *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entitles 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 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 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.*

This document may be returned to the Kean University Office of Human Resources confidential fax line 908-737-3319.

Serious Health Condition - Medical Certification

Instructions to Employee

To request a leave of absence from Kean University due to your own medical condition pursuant to the Family and Medical Leave Act, and/or your collective bargaining agreement, employees are required to provide the **Serious Health Condition - Medical Certification** completed by your Health Care Provider (HCP). This documentation may be faxed to the confidential fax line 908-737-3319 by your HCP. If you fail to provide sufficient medical certification to substantiate the need for leave, the request for leave of absence may be denied.

Please note that a leave of absence is a period of time that has been designated by your physician to be required for treatment or recovery from injuries or illnesses. Therefore, employees are not allowed to perform work during a medical leave of absence period of time (whether this represents continuous days or a reduced/ intermittent schedule of days). This includes work conducted on campus, as well as work-from-home or offsite.

Confidentiality

Employee medical records are to be submitted directly to the Office of Human Resources. All employee medical information obtained by the Office of Human Resources related to a leave of absence request is considered confidential. These records are stored separately from other employment records, and accessed only by authorized personnel such as members of the Office of Human Resources, Benefits team.

Supervisors and managers of the employee may need to know about necessary leave of absence dates, return to work restrictions or accommodation requests in order to make decisions, such as whether they can accommodate an employee on light duty or the time frame to cover an absence. The Office of Human Resources (HR) will allow limited information to be shared only with supervisors and managers such as necessary restrictions / accommodations. HR will not provide details on the medical condition itself. Private Health Information (PHI) is not shared with the employee's supervisor(s).

Further details regarding leave of absence, may be found on the HR website. *Questions regarding Leave of Absence may be addressed to Lorice Thompson-Greer in the Office of Human Resources (lgreer@kean.edu or 908-737-3309)*

DEFINITIONS

Incapacity

An inability to perform the functions of one's job owing to the serious health condition.

Serious Health Condition

Inpatient Care • An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

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

Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.