TEXAS A&M UNIVERSITY CORPUS CHRISTI | HUMAN RESOURCES
OUR SERVICES - YOUR FUTURE

FAMILY MEMBER'S CONDITION — Certification of Health Care Provider Form

Employee Instructions : This form must be completed by a practitioner for the employee's family member's health condition. The employee should provide this information to his/her department for the purposes of sick leave usage, sick pool eligibility, and Family and Medical Leave Act (FMLA) eligibility.

Physician's Instructions : 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 are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes 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. Please provide medical history information regarding your patient only to the extent necessary to fully respond to all relevant items below

1. Texas A&M Employee Name	**2. Patient (employee's family member)**	**3. Date**
4. Patient's relationship to Texas A&M employee: ☐ Child → If child, list date of birth: ☐ Spouse ☐ Parent ☐ Other: _____	**5. Medical facts, symptoms, or diagnosis of patient's condition:**	

6. Approximate date condition commenced:	**7. Estimated duration of condition:** ☐ Lifetime ☐ Unknown ☐ Undetermined ☐ Other (list approximate end date if possible): _____	**8. Is condition pregnancy?** ☐ Yes ☐ No If yes, expected delivery date:_____

9. FOR FMLA ELIGIBILITY: Please check any applicable category or categories relating to the PATIENT referenced in box 2:

a. ☐ **Incapacity of More Than Three Calendar Days -** This period of incapacity involves:
- treatment two or more times by a health care provider;
- treatment by a health care provider on at least one occasion with prescribed medication; and/or
- treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment (including prescriptions)

b. ☐ **Pregnancy** – Any period of incapacity due to pregnancy or for prenatal care.

c. ☐ **Hospital Care** – inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility

d. ☐ **Intermittent Incapacity / Chronic Conditions Requiring at Least Two Treatments Per Year** (i.e., migraine headaches, diabetes, fibromyalgia)

e. ☐ **Permanent/Long-term Conditions Requiring Supervision** – (i.e., Alzheimer's, severe stroke, terminal illness)

f. ☐ **Multiple Treatments (Non-Chronic Conditions)** – (i.e., physical therapy for severe arthritis or dialysis for kidney disease)--

g. ☐ **None of the Above.**

10. AMOUNT OF CARE NEEDED: Please check the following statement(s) that apply to the patient's need for the employee's care resulting from the injury or illness. Such care may include basic medical care and hygiene, transportation, psychological comfort, etc.:

a. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including time for recovery? ☐No ☐Yes
If yes, estimate the beginning date of incapacity_____and estimate the employee's return to work date (the date the patient no longer needs the employee's care) _____.

b. Will the employee need to remain off work to care for the patient until the patient's next medical evaluation? ☐No ☐Yes
If yes, give next date of evaluation: _____.

c. Will the patient require care on an intermittent or reduced schedule basis, including time for recovery? ☐No ☐Yes
If yes, estimate the hours the patient needs care on an intermittent basis, if any:

_____ hours per day, _____ days per week from _____(date) through _____(date).

d. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐No ☐Yes
Will the patient need care during the episodic flare-ups? ☐No ☐Yes
If yes →Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per ☐week ☐month **Duration:** _____ ☐hour(s) or ☐day(s) per episode.

11. FOLLOW-UP APPOINTMENTS, REGIMEN OF TREATMENT, ETC. FOR PATIENT IN BOX 2:

Will the employee be needed to assist the patient to attend follow-up treatment appointments because of his/her medical condition? ☐Yes ☐No

If Yes, please provide the date(s) of the scheduled appointments. If date(s) are not firm, please estimate:

12. EMPLOYEE: Describe the care you will provide to your family member and estimate the leave needed to provide the care:

_____ _____

EMPLOYEE SIGNATURE **DATE**

13. PRACTITIONER: Please give any additional information, if any, relative to previous questions in this form:

Physician's Signature:_____ Date:_____

Physician's Printed Name:_____ Telephone Number:_____

Field of Specialty:_____ Fax Number:_____

SUBMIT FORM TO

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