



CERTIFICATION OF HEALTH CARE PROVIDER FORM *

Information on this form is confidential and private and will be shared strictly on a need to know basis.

SECTION 1: TO BE COMPLETED BY EMPLOYEE

1A. EMPLOYEE INFORMATION

Employee's Name (Last, First, MI)

USNH ID#

Home Address (City, State, ZIP)

UNH Department

1B. IF LEAVE REQUEST IS FOR THE CARE OF A FAMILY MEMBER

Patient's Name (Last, First, MI)

*Date of Birth ***

Relationship to Employee

***Date of Birth – To qualify under the Family and Medical Leave Act, if you are taking leave to care for your son or daughter, he or she must be under the age of 18. A child over age 18 may qualify if he or she has a serious health condition, is incapable of self-care, and is incapacitated because of a mental or physical disability.*

1C. SIGNATURE OF EMPLOYEE

I authorize release of the information requested on this form.

Signature

Name (Please Print)

Department

Date

** This form is used for faculty and staff medical leaves including those covered by the Family and Medical Leave Act. This form is also used when a faculty or staff member requests a workplace accommodation for medical reasons.*

SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER

(Re-certification may be required)

2A. MEDICAL FACTS

Describe the medical facts, either for the employee's own condition, or the employee's immediate family member (for example: symptoms, diagnosis, regimen of continuing treatment, and/or need to use specialized equipment for treatment).

2B. DATES

- I. Approximate date the condition commenced:
Employee's stop work date (date leave begins, if applicable):
Employee's expected return to work date (if applicable):
Probable duration of the patient's present incapacity:
Probable duration of the condition (if different from incapacity):
Will the condition be in effect for more than six months? Yes No
For maternity leave - Due date:
Employee's stop work date (if different from Due Date):
Employee's return to work date (when medically able; normally six weeks following the birth):

- II. Will it be necessary for the employee to work intermittently or to work on a less than full schedule? Yes No
If yes, please give the probable duration and describe the schedule:

- III. If the condition is chronic, meaning ongoing, or a pregnancy, state whether the patient is presently incapacitated and also the likely duration and frequency of episodes of incapacity:

2C. TREATMENTS¹

- I. If additional treatments will be required for the condition, please provide an estimate of the probable number, the interval between, and any period required for recovery. Indicate if treatments will cause absence from work or the inability to perform other daily activities :

- II. If any treatments will be provided by another health service provider (e.g., physical therapist), please state the nature of these treatments:

- III. If a regimen of continuing treatment is required under your supervision, please provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

2D. EMPLOYEE'S ABILITY TO PERFORM WORK *(This section does NOT apply to Family or Parental Leave)*

- I. If this certification relates to the employee's own health condition (including pregnancy or an ongoing chronic condition), is the employee able to perform work of any kind? Yes No

- II. If yes, please identify any essential functions of the employee's job that he or she cannot perform (the employee or employer should supply you with information about the essential job functions):

- III. Can you suggest any accommodations that can be made so the employee will be able to perform the essential functions listed above?

- IV. Is it necessary for the employee to be absent from work for treatment? Yes No

¹ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations.

2E. FAMILY CARE LEAVE

I. Explain your patient's need for care by the employee and why such care is medically necessary.

II. Is the employee's leave related to the birth of a child (parental leave)? Yes No

III. Include a schedule and duration if the leave is to be taken intermittently or if it will be necessary for the employee to work less than his or her full schedule:

IV. Does the patient require the employee's assistance for basic medical/personal needs or for safety or transportation?
 Yes No If yes, please describe:

V. Is the employee's presence needed to provide psychological comfort to assist in the patient's recovery?
 Yes No

2F. SIGNATURE OF HEALTH CARE PROVIDER

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| | | |
| <i>Signature</i> | <i>Name (Please Print)</i> | <i>Date</i> |

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| | | |
| <i>Title</i> | <i>Type of Practice</i> | <i>Telephone</i> |

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| | |
| <i>Address</i> | <i>Fax</i> |

RETURN COMPLETED FORM TO:
Office of Human Resources
UNIVERSITY OF NEW HAMPSHIRE
2 Leavitt Lane, Durham, NH 03824
Fax: 603-862-0517