Fashion Institute of Technology
State University of New York

MUST BE RETURNED TO THE OFICE OF HUMAN RESOURCES NO LATER THAN _____

CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FMLA)

EMPLOYEE/FAMILY MEMBER INFORMATION

Employee Name: _____

Name of family member for whom you will provide care: _____

Relationship: ☐ Parent ☐ Spouse ☐ Child (Date of birth_____) ☐ Domestic or Civil Union Partner ☐ Parent-in-law ☐ Other:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____ _____

Employee Signature Date

TO BE COMPLETED BY FAMILY MEMBER TO PERMIT CONTACT WITH HEALTH CARE PROVIDER:

I **[☐do / ☐do not]** give the College permission to contact my health care provider(s) in order to clarify any medical certification submitted to justify my family member's leave. ***Note: Your failure to give permission will be one of the factors the College considers in determining whether to request a second medical opinion.***

_____ _____

Patient Signature Date

MEDICAL FACTS

1. Approximate date condition commenced: _____
   Probable duration of condition: _____
2. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___ No____Yes If yes, dates of admission: _____
3. Date(s) you treated the patient for condition: _____
   Was medication, other than over-the-counter medication, prescribed?_____No_____Yes
   Was the patient referred to other health care provider(s) for evaluation or treatment (*e.g.*, physical therapist?)
   ___ No____Yes If yes, state the nature of such treatments and expected duration of treatment: _____
   _____
   _____
4. Is the medical condition pregnancy?_____No_____Yes If yes, expected delivery date: _____
5. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   _____
   _____

AMOUNT OF CARE NEEDED

6. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?
   _____No _____Yes Estimate the beginning and ending dates for the period of incapacity: _____
   During this time, will the patient need care? _____No _____Yes
   Explain the care needed by the patient and why such care is medically necessary: _____

7. Will the patient require follow-up treatments, including any time for recovery?_____No _____Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: Please use this format Date: xx-xx-xxxx to xx-xx-xxxx

_____

Explain the care needed bythe patient, and why such care is medically necessary: _____

_____

8. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

___ No____Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hours per day;_____days per week from_____through _____

Explain the care needed bythe patient, and why such care is medically necessary: _____

_____

_____

9. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?____No_____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 that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency:_____times per_____weeks_____months

Duration:_____hours or_____days per episode

Does the patient need care during these flare-ups?__ No_Yes

Explain the care needed by the patient, and why such care is medically necessary:_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NO. (USE ADDITIONAL SHEETS IF NECESSARY)

_____

_____

_____

_____

HEALTH CARE PROVIDER INFORMATION

_____ _____

Signature of Health Care Provider Date

Provider's name and business address: _____

_____

Type of practice / Medical specialty: _____

Telephone:_____ Fax: _____

PLEASE RETURN FULLY COMPLETED FORM TO:

Office of Human Resources Fashion Institute of Technology 333 7th Avenue, 16th Floor
New York, NY 10001-5992

Temporary eFax: (917) 456-9519
or Confidential Fax: (212) 217-3651

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