



CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE’S SERIOUS HEALTH CONDITION (FMLA)

EMPLOYEE NAME: _____

Employee’s job title: _____ (See attached for Employee’s essential job functions)

Regular work schedule: _____

TO BE COMPLETED BY EMPLOYEE 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 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.*

Employee Signature

Date

THE GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) SAFE HARBOR NOTICE

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 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.

MEDICAL FACTS

- Approximate date condition commenced: _____
Probable duration of condition: _____
- Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___ No ___ Yes If yes, indicate dates of admission: _____
- Date(s) you treated the patient for condition: _____
Will the patient need to have treatment visits at least twice per year due to the condition? ___ No ___ Yes
Was medication, other than over-the-counter medication, prescribed? ___ No ___ Yes
Was the patient referred to other health care provider(s) for evaluation/treatment (e.g. physical therapist)?
___ No ___ Yes (State nature and expected duration of treatment): _____
- Is the medical condition pregnancy? ___ No ___ Yes. If yes, expected delivery date: _____
- Is the employee unable to perform any of his/her job functions due to the condition: ___ No ___ Yes
If yes, identify the job functions the employee is unable to perform: _____
- Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): _____

AMOUNT OF LEAVE NEEDED

7. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___ No ___ Yes

If yes, estimate the beginning and ending dates for the period of incapacity: _____

8. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ No ___ Yes

If yes, are the treatments or the reduced number of hours of work medically necessary? ___ 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: _____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

9. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ___ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?

___ No ___ Yes If yes, explain: _____

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 _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

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:

Johanny Tavares
Office of Human Resources
Fashion Institute of Technology
236 W. 27th Street, 11th Floor
New York, NY 10001-5992

or Confidential Fax: (212) 217-3652

ATTACH ESSENTIAL JOB FUNCTIONS