Fashion Institute of Technology

Seventh Avenue at 27 Street
New York City 10001-5992
www.fitnyc.edu

MUST BE RETURNED TO THE EMPLOYER BY ____________________

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

<u>TO BE COMPLETED BY FAMILY MEMBER TO PERMIT CONTACT WITH HEALTH CARE PROVIDER:</u>

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

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

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:

   ____

   Explain the care needed by the 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 by the 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)

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____

____

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:

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

or Confidential Fax: (212) 217-3660