

Supporting Medical Certification (complete unless #7 is checked):

Medical Facts. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories of serious health condition:

Anticipated Duration

1. What is the approximate date the condition commenced, and what is the probable duration of the condition?
2. When did the incapacity commence? (Incapacity is the inability to work, attend school or perform other regular daily activities.)
3. What is the probable duration of the patient's present incapacity?
4. Will it be necessary for the employee to be absent intermittently or to work on a reduced-time schedule as a result of the condition?
 Yes No
5. If YES, what is the probable duration of this intermittent or reduced-time schedule?

For Pregnancy-Related Conditions (#3) OR Chronic Conditions (#4)

1. Is the patient presently incapacitated? Yes No
2. What is the likely duration and frequency of episodes of incapacity?

Treatment

1. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.
2. If the patient will be absent from work or other daily activities because of treatment intermittently or on a reduced-time schedule, provide:
 - a) An estimate of the probable number and intervals between such treatments
 - b) Actual or estimated dates of treatment, if known, and
 - c) Period required for recovery, if any
3. Can treatments be scheduled during non-work hours? Yes No
4. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:
5. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

Ability to Work

1. If medical leave is required for the employee's own condition, is the employee **unable** to perform work of any kind? Yes No
2. If able to perform some work, is the employee **unable** to perform any one or more of the essential functions of the employee's job?
 Yes No Identify the function(s) (Essential Job Functions attached) the employee is **unable** to perform:
3. If neither 1 nor 2 applies, is it necessary for the employee to be absent from work for treatment? Yes No

Leave to Care for Family Member

1. Does the employee's family member require assistance for basic medical or personal needs or safety, or for transportation?
 Yes No
2. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?
 Yes No
3. If the patient will need care only intermittently or on a reduced-time schedule, what is the probable duration and frequency of this need?

Space for additional information for any of the above questions:

By providing my original signature, the undersigned health care provider certifies that the information is true and accurate.		
Printed Name of Health Care Provider	Type of Practice	License Number
Address		Telephone Number
Name and Title of Person Completing the form, if not the Health Care Provider		
Signature of Health Care Provider	Date	

Return completed form to the employee or return it directly by mail or fax to:

Linda S. Harrison
Manager of Employee Benefits
Edinboro University of PA
219 Meadville Street – Reeder Hall
Edinboro, PA 16444
Telephone: (814) 732-1348
Fax: (814) 732-2885

Employee Certification and Authorization

Family & Medical Leave Act

Commonwealth of Pennsylvania

Employee Certification and Authorization:	
I understand that the Serious Health Condition Certification form is to be completed fully, accurately and completely by my treating health care provider.	
I have the option to allow the Commonwealth's designated medical representative to contact my treating health care provider to obtain clarification of the information provided on the Serious Health Condition Certification form, which may reduce the need for me to personally request the health care provider to clarify information that is not complete or legible.	
<input type="checkbox"/> I agree <input type="checkbox"/> I do not agree	
Employee Signature	Date

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