FIT **Fashion Institute of Technology**
State University of New York

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

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

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, indicate dates of admission: _____

3. 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): _____
   _____

4. Is the medical condition pregnancy? ☐ No ☐ Yes. If yes, expected delivery date: _____

5. 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: _____
   _____
   _____
   _____

6. 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): _____
   _____
   _____
   _____
   _____
   _____

***On line #7, please use the following date format MM/DD/YYYY - MM/DD/YYYY.**

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

or **Temporary eFax: (917) 456-9519**

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