Instructions to the Employee: Please complete the top section before giving this form to your medical provider. The Family Medical Leave Act (FMLA) permits Texas Health Resources to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition or to care for a covered family member with a serious health condition. Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request.

Employer: Texas Health Resources
Contact: Integrated Disability Management Department
612 E. Lamar Blvd., Suite 400, Arlington, TX 76011
Email: THRIntegratedDisabilityManagement@texashealth.org
Phone: 1-800-958-4878 Fax: 682-236-7018

Employee Name: _____ Employee ID#: _____
Employee's Job Title: _____ Regular Work Schedule: _____
Essential Job Functions: _____
Job Description Attached: Yes ☐ No ☐
Name of Qualifying Family Member (if requesting leave to care for family): _____
Relationship of Family Member: _____
Dependent Child's Date of Birth (if applicable): _____
Describe the care you will provide to your family member and estimate leave time needed to provide care:

_____

_____

Employee Signature: _____ Date: _____

Please note: This form is due 15 days from the day you request leave or 7 days from the day you request a leave extension.

The remaining sections are to be completed by the Health Care Provider

Instructions: The employee listed above has requested leave under FMLA to care for their own condition or that of a family member. Please answer fully and completely all applicable sections. Several questions seek a response as to the frequency or duration of a condition, treatment etc. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can, terms such as lifetime, unknown or indeterminate may not be sufficient to determine FMLA coverage. Limit responses to the patient's condition for which the employee is seeking leave. Please be sure to complete the second page and sign the form.

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?
Yes ☐ No ☐ Dates of admission: _____ Dates you treated the patient: _____

_____

Will the patient need to have treatment visits at least twice per year due to the condition? No ☐ Yes ☐ Explain:

_____

Was medication other than over-the-counter medication prescribed? No ☐ Yes ☐ Explain:

_____

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
No ☐ Yes ☐ Nature *and* expected duration of such treatments: _____

_____

Is the medical condition pregnancy? No ☐ Yes ☐ Expected Delivery Date: _____

Is the employee unable to perform any of his/her job functions due to the condition? No ☐ 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: _____

_____

_____

Continuous Amount of Leave Time Needed

Will the employee/family member be incapacitated for a single continuous period of time due to his/her medical condition? Yes ☐ No ☐ If so, estimate the beginning and ending dates for the period of incapacity:
Beginning Date: _____ Ending Date: _____

Intermittent Leave Time Needed

Beginning Date: _____ Ending Date: _____
Will the employee/family member need to attend follow-up treatment appointments or work part-time or on a reduced schedule? Yes ☐ No ☐ If so, treatment schedule, if any, including the dates of scheduled appointments and the time required for each appointment, including any recovery period: _____

_____

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? Yes ☐ No ☐ Is it medically necessary for the employee to be absent from work during the flare-ups? Yes ☐ No ☐ If yes explain: _____

_____

Based on 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: _____ episode(s) _____ time(s) per _____ week(s) _____ month(s)
Duration: _____ hour(s) or _____ day(s) per episode

Additional Information: _____

_____

_____

Provider's Name: _____
Business Address: _____
Type of practice/medical specialty: _____
Signature of Health Care Provider: _____ Date: _____

Return completed forms to:
Texas Health Resources IDM at 682-236-7018 (fax) or 612 E. Lamar Blvd., Suite 400, Arlington, TX 76011 Email: THRIntegratedDisabilityManagement@TexasHealth.org

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. To comply with this law, we are asking that you do 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 members genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and the 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.