Certification of Healthcare Provider – Family Member's Serious Condition

Section I - To be completed by Employee

Employee/Patient Name:	Employee Job Title:	
Employer Phone: **858.513.9240 x11824**	Employer Fax: **866-587-2184**	Employer Email: **LOA@ashford.edu**

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____ If is your child, their date of birth: _____

If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability?
☐ No ☐ Yes

Section II - To be completed by Health Care Provider

Name of Health Care Provider:	Place office stamp here:
Address:	
Phone:	

INSTRUCTIONS TO HEALTHCARE PROVIDER: The employee listed above has requested a leave of absence to care for your patient. Please answer, fully and completely, all applicable parts. 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. Limit your responses to the condition for which the patient needs the employee's care. Be sure to sign and date the form below.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA):
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.

Note: Do not disclose the employee's underlying diagnosis without his/her consent.

Part A: Medical Facts

1. 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, date(s) of admission: _____

   Date(s) you treated the patient for condition: _____

   Will the patient need to have treatment periodically 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 or treatment (i.e. physical therapist)?
   ☐ No ☐ Yes If yes, state the expected duration of treatment: _____

Part B: Amount of Leave Needed:

Continuous Period of Time

2. Will the patient 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, please estimate the beginning ***and*** ending dates for the period of incapacity below:

   The anticipated duration of incapacity: _____ through _____
   Start Date Estimated End Date
3. During this time, does the patient's condition warrant participation of the employee? ☐ No ☐ Yes
   Explain the care needed by the patient and state whether such care is medically necessary:

   _____

   _____

Intermittent or Reduced Schedule

Answer questions 4 and 5 only if the employee requires leave on an intermittent or reduced schedule basis

4. Is it medically necessary for the patient to receive care on an intermittent or reduced schedule basis, including any time for recovery? (other than for episodic flare-ups which are addressed in question #5 below)? ☐ No ☐ Yes If yes, estimate the hours the patient needs care from the employee:
   Hours Per Day _____ Days Per Week _____ From _____ Through _____
   Explain the care needed by the patient, and state whether this care is medically necessary:

   _____

   _____

5. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?? ☐ No ☐ Yes

   Does the patient need care during these flare-ups? ☐ No ☐ Yes (if, please answer below)
   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. For example, 1 episode every 3 months lasting 1-2 days per episode for the next 6 months:

   Frequency: _____ times per: ☐ week ☐ month ☐ other: _____
   Duration of flare-up per episode: _____ hours or _____ day(s) per episode
   The anticipated duration of when a flare-up could happen: _____ through _____
   Start Date Estimated End Date
   Explain the care needed for the patient that is medically necessary:

   _____

   _____

Health Care Provider's Signature

Signature: Date: