State of Connecticut Human Resources

Medical Certificate

Return to:

Agency Name: University of Connecticut *Attn: Human Resources*

Address: 9 Walters Avenue, Storrs, CT 06269 *FAX:* (860) 486-0406

Must be submitted within 30 days of foreseeable leave, if leave is FMLA qualifying.

Form #: P33A - Employee

Revision Date: 2/2011

To be used by employee who is absent for personal illness, including FMLA absences.

AGENCY INSTRUCTIONS

This medical certificate is to be used by an employee who is or will be absent for health reasons including the birth of a child. It shall be given to the employee or sent directly to his physician or practitioner. The name of the person and the address of the agency to which this certificate is to be returned shall be inserted in the space provided. The PHYSICIAN OR PRACTITIONER will generally return the filled out certificate to the agency head or authorized representative. Fill in employee's name, position and address below.

AGENCY FILL IN

Agency Head or Representative	Agency Name
Danielle Toger	University of Connnecticut

Agency Address *(No. and Street)* *(City or Town)* *(State)* *(ZIP Code)*
9 Walters Avenue, Storrs, CT 06269

Employee's Name and Employee's Number

Employee's Position	Department

Address *(No. and Street)* *(City or Town)* *(State)* *(ZIP Code)*

CONDITIONS GOVERNING ISSUANCE

No sick leave, federal FMLA, state family/medical leave (C.G.S. 31-51kk), special leave with pay in excess of five (5) days, or leave as otherwise prescribed by contract, shall be granted state employees unless supported by a medical certificate filed with, and acceptable to, the appointing authority. The period of incapacity (including, in the case of pregnancy, the period of time before and after birth when the employee is unable for medical reasons to perform the requirements of her job) must be reported with a description of the nature of the incapacity entered under (2) and/or (7).

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.

This form must be executed by a physician or practitioner whose method of healing is recognized by the State, except where otherwise indicated.

Note: The health care provider must practice in the specialty for which the patient is being treated.

(1) Pages 3-4 of this form describes what is meant by a **"serious health condition" / "serious illness"** under federal FMLA and state family/medical leave (C.G.S. 31-51kk). Does the patient's condition qualify under any of the categories described? *(Please be sure to refer to pp. 3 and 4 for specific definitions.)* _____ If yes, please check the appropriate category:
(fill in "yes" or "no")

____ Inpatient care with overnight stay ____ Permanent/long-term conditions requiring supervision
____ Incapacity and treatment ____ Multiple treatments (non-chronic conditions)
____ Pregnancy (includes prenatal) ____ None of the above
____ Chronic conditions requiring treatments

(2) If this absence is for an FMLA qualifying reason, describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories on pages 3-4. If this absence is not for an FMLA qualifying reason, describe the medical facts that support your certification of the employee's medical condition and incapacity from work. If additional space is needed, continue remarks under Section (7).

_____

_____

(3) (a) Answer the following:

1. The approximate **date** the condition commenced. _____
2. The probable **duration** of the condition. _____
3. The probable duration of the patient's present **incapacity** (if different from (3)(a) 2. above).

_____

4. The date of the employee's most recent examination for the condition. _____

(b) Will it be necessary for the employee to take work only **intermittently** or on a **reduced schedule** as a result of the condition (including for treatment described in **ITEM (4)** below)?
_____ If yes, give the probable **duration** and **frequency**._____
(fill in "yes" or no") *(fill in no. of months or days, etc.)*

TO BE FILLED IN BY ATTENDING PHYSICIAN OR PRACTITIONER
(Please print legibly.)

(c) If condition is a "**chronic condition"** (as checked off under Section (1)) or **pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

____ Patient ____ *is* ____ *is not* presently incapacitated. *(check one)*

Going forward, estimate the:

____ **Duration** of episodes of incapacity = _____ *(hours or days, etc.)*

____ **Frequency** of episodes of incapacity = _____ *(no. of times per week or month, etc.)*

(4) (a) If **additional treatments** will be required for the condition and/or the patient will be absent from work or other daily activities because of treatment on an **intermittent** or **part-time** basis, provide:

____ An estimate of the probable **number** of such treatments. _____

____ An estimate of the probable **interval between** such treatments. _____

____ An actual or estimated **dates** of treatment, if known. _____

____ Period required for **recovery**, if any. _____

(b) If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatment and period of time covered.

_____

_____

(c) 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). _____

_____

(5) (a) During the period of incapacity, is the employee **able to perform work of ***any*** kind**?

_____
(fill in "yes" or "no")

(b) 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** (if FMLA leave or if relevant, a job specification is enclosed for your convenience)? _____
(fill in "yes" or "no")

If yes, elaborate. _____

_____

(c) If neither (4)(a) or (4)(b) applies, is it necessary for the employee to be absent from work for treatment? _____
(fill in "yes" or "no")

(6) The employee will be able to return to ☐ **regular** or ☐ **selective work** on

_____ *(date)*. If selective work, explain under number (7) below.

(7) Additional remarks:

_____

_____

_____

Name of Physician or Practitioner **AND** Physician or Practitioner License Number *(please type or print)*			
Address *(No. and Street)*	*(City or Town)*	*(State)*	*(ZIP Code)*
Signed *(Physician or Practitioner)*	Date	Telephone	

FEDERAL FMLA:

Under the federal FMLA, "**Serious Health Condition**" is defined as an illness, injury, impairment, or physical or mental condition that involves:

- Any period of incapacity or treatment related to inpatient care (i.e., an overnight stay in a hospital, hospice, residential facility, **OR**
- Continuing treatment by a health care provider.

"**Continuing treatment**" by a health care provider includes any one or more of the following:

1) Incapacity and Treatment:: A period of incapacity of more than three consecutive full calendar days and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
   - Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, , **OR**
   - Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

   Treatment means an in-person visit to a health care provider. The first (or only) in-person treatment visit
   must take place within **seven** (7) days of the first day of incapacity.

2) Pregnancy: Any period of incapacity due to pregnancy, or for prenatal care.

3) Chronic Conditions Requiring Treatments: Any period of incapacity or treatment for such incapacity due to a chronic condition which:
   - Requires periodic visits for treatment by a health care provider or by a nurse physician's assistant under direct supervision of health care provider;
   - Continues over an extended period of time (including recurring episodes of a single underlying condition); **AND**
   - May cause episodic rather than a continuing period of incapacity. **Examples**: *asthma, diabetes, epilepsy*.

4) Permanent/Long-term Conditions: A period of incapacity, which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. **Examples**: *Alzheimer's, a severe stroke, or the terminal stages of a disease*.

5) Multiple Treatments (Non-Chronic Conditions): Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment. **Examples**: *cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), and kidney disease (dialysis).*

Note: Substance abuse may be a serious health condition if the conditions mentioned above are met. However, FMLA leave may only be taken for *treatment* for substance abuse by a health care provider or by a provider of health care services on referral by a health care provider. On the other hand, absence *because of* the employee's use of the substance, rather than for treatment, does **not** qualify for FMLA leave.

***Please Note*: For the purposes of federal FMLA the following terms are defined to mean:**

- "**Incapacity**" – inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.
- "**Treatment**" – includes examinations to determine if a serious health condition exists and evaluations of the condition. It does not include routine physical examinations, eye examinations, or dental examinations.
- A "**regimen of continuing treatment**" – includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. It does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.
- **"Intermittent Leave"** – is leave taken in separate blocks of time due to a single qualifying reason.
- **"Reduced Leave Schedule"** – is leave schedule that reduces an employee's usual number of working hours per work-week or hours per workday. It is a change in the employee's schedule for a period of time, normally from full-time to part-time.

STATE FAMILY / MEDICAL LEAVE (C.G.S. 31-51kk):

Under the state's family/medical leave law, "**Serious Illness**" is defined as an illness, injury, impairment or physical or mental condition that involves:

- Inpatient care in a hospital, hospice, or residential care facility;
  OR
- Continuing treatment or continuing supervision by a health care provider.

EMPLOYEE FITNESS FOR DUTY CERTIFICATION

Employee's name: _____

Supervisor: _____

Date leave commenced: _____

Date of return: _____

I understand that following my medical leave under federal FMLA and/or C.G.S. 31-51kk my restoration to employment is subject to the following conditions:

1. As a condition of restoration, I must provide a written certification from my health care provider certifying that I am able to resume working.
2. Every attempt will be made to restore me to my original position. If my original position is unavailable, I will be placed in an equivalent position with equivalent pay and benefits, unless contract specifies otherwise.
3. If I am returning from *unpaid* family and medical leave, I shall not be entitled to the accrual of any seniority or employment benefits during the period of leave, unless contract specifies otherwise.

Employee's signature: _____ **Date**: _____

I have examined _____ and can certify that she/he is fully able to resume working on _____
(employee name) (date)

_____

_____

_____

Health care provider's signature: _____ **Date**: _____

Name: _____ **Telephone**: ( ) _____
(please print)

Address: _____