Medical Leave of Absence Form
(Non-FMLA)
Employee Serious Health Condition
For Health Care Provider

EMORY UNIVERSITY
Human Resources - Employee Relations
1599 Clifton Road, Suite 5.408
Atlanta, Georgia 30322
HIPAA Compliant Fax Number:
404-712-5205

A job description has been provided to the employee and must be attached to this form.

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your healthcare provider. This form permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for Non FMLA medical leave due to your own serious health condition. Failure to provide a complete and sufficient medical form may result in a denial of your request. We need to receive this form within two weeks of submission.

Your name: ____________________________________________
First ____________________________________________ Middle ____________________________________________ Last ____________________________________________

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested a Non FMLA medical leave of absence. 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. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider’s name and business address: ____________________________________________

Type of practice / Medical specialty: ____________________________________________

Telephone: ____________________________ Fax: ____________________________
PART A: MEDICAL FACTS

1. Approximate date condition commenced: ________________________________
   
   Probable duration of condition: ________________________________
   
   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   __ No  __ Yes. If so, dates of admission:
   
   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 or treatment (e.g., physical therapist)?
   __ No  __ Yes. If so, state the nature of such treatments and expected duration of treatment:
   
   2. Is the medical condition pregnancy? __ No  __ Yes. If so, expected delivery date: __________________________
   
   3. Use the information provided by the employer in Section I to answer this question. If the employer fails to
   provide a list of the employee’s essential functions or a job description, answer these questions based upon
   the employee’s own description of his/her job functions.
   
   Is the employee unable to perform any of his/her job functions due to the condition: __ No  __ Yes.
   
   If so, identify the job functions the employee is unable to perform:
   
   4. 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):
   
   _____________________________________________________________
   
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   _____________________________________________________________
PART B: AMOUNT OF LEAVE NEEDED

5. 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 so, estimate the beginning and ending dates for the period of incapacity: ____________________________

6. 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 so, 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 ____________

7. 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 so, 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 NUMBER WITH YOUR ADDITIONAL ANSWER.
Upon completion, please fax this form and job description provided by employee to:

404-712-5205
(Fax Number is HIPAA compliant)