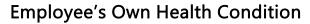
Health Care Provider Certification





Colorado Family and Medical Leave Insurance (FAMLI)								
Employer : Colorado State University Address : 6004 Campus Delivery 555 South Howes St, 2 nd Fl Fort Collins, CO 80523-600	oor Secure Portal 1	Phone: 970-491-6947 Secure Portal for Upload Email: HR_leave@colostate.edu Website: https://hr.colostate.edu/colorado-famli-program/						
Important tips when completing this form To request Colorado FAMLI benefits, you will need to return this medical certification form to CSU Human Resources. To start, complete Section 1 and send it to your treating healthcare provider to complete Section 2 and return to us with your Application and any other supporting documents as part of your claim for benefits.								
Section 1: For Completion by the Employee								
First Name	Last Name	Date of Birth	Last 4 Digits of SSN					
Address, City, State, Zip Code								
Cell number	Home Number	Work Number						
Section 2: For Completion by the Treating Health Care Provider								
Your patient made a request to be absent from work because of their own illness or injury. For us to make a decision on their claim for CO FAMLI benefits, we will need you to complete the information in Section 2. When completing this certification, we ask:								
 Your answers are to be your best estimate based on your medical knowledge, experience, and examination of the patient. Be as specific as you can. Using terms like "as needed", "unknown" or "indeterminate" may not be enough to approve the claim. 								
 Limit your responses to the health condition for which your patient is seeking leave. If your patient needs leave due to more than one health condition, please complete a separate certification for each condition. Do not include information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b). 								
Check the box(es) for the questions below, as applicable.								
☐ Inpatient Care: The patient (☐ was / ☐ is/ ☐ will be) admitted for an overnight stay in a hospital, hospice, or residential								
medical care facility on the following date(s):								
Incapacity plus Treatment: (e.g. outpatient surgery, strep throat)								
 Due to the patient's health condition, the patient (□ was / □ is/ □ will be) incapacitated for more than three consecutive, full calendar days. 								

The health condition (□ had / □ has/ □ will) also result(ed) in a course of continuing treatment under the supervision of a

health care provider (e.g., prescription medication (other than over the counter), therapy requiring special equipment, etc.)

Continued on next page

• The patient (\square was / \square is/ \square will be) seen on the following date(s):

Health Care Provider Certification Employee's Own Health Condition

Employee's Name	Date of Birth			
Section 2: For Completion by the	Treating Health Care Provider (continued)			
Continued from previous page	Treating freatth care Frovider (continued)			
	spected delivery date:(mm/dd/yyyy)			
Is this a pregnancy or childbirth complication? □ Yes				
	ches) Treatment visits are expected to be at least twice per year			
the continuing supervision of a health care provider (even Health Conditions requiring Multiple Treatments: (e.g., condition, it is medically necessary for the patient to recondition).	hemotherapy treatments, restorative surgery, etc.) Due to the health			
Date health condition commenced:	Last office visit:			
Date you first examined the patient for this health	Last office visit:			
condition:	Provide your best estimate of how long the health condition lasted or will last:			
based upon the patient's own description of the essential jo medical treatment(s), such as scheduled medical visits, for a job functions of the position during the absence for treatment	s not able / □will not be able) to perform one or more of the essential			
Provide the relevant medical facts relating to the health consymptoms, or any regimen of continuing treatment such as	dition requiring this leave (these facts may include diagnosis, the use of specialized equipment):			
Continued on next page				

Health Care Provider Certification Employee's Own Health Condition

Employee's Name			Date of Birth			
Section 2: For Completion by the Treating Health Care Provider (continued)						
Check the applicable box(es) and complete the information that best describes the type of time away from work that the applicant will need for their own health condition.						
☐ Continuous leave						
My patient has/will be incapacitated for a single continuous period due to their own health condition, including time for treatment and recovery beginning/ and ending/						
☐ Reduced Work Schedule leave	2					
My patient will need to work a reduced work schedule due to their own health condition and associated treatment and recovery period beginning/ and ending/						
Patient's work capacity is up to hours per week.						
☐ Intermittent leave						
My patient is expected to have periodic flare-ups or follow-up treatment appointments where intermittent absence from work will be medically necessary beginning/and ending/						
Patient's incapacity may occur up to hours per week.						
Designated Representative						
First Name	Last Name		Relationship to t	Relationship to the Employee		
Address, City, State, Zip Code						
Cell Number Home Number		Number		Work Number		
Health Care Provider Information and Signature						
Print Treating Health Care Provider Name:			Specialty/Board Certification:			
Treating Health Care Provider's Business address (Include County if practicing in Colorado):						
Certification License number and State:			NPI number (Required if practicing outside of Colorado):			
Telephone:	Fax Number: Ema		l iil Address:			
Treating Health Care Provider Signature: Date:						