Health Care Provider Certification
Employee's Own Health Condition

HUMAN RESOURCES
COLORADO STATE UNIVERSITY

Colorado Family and Medical Leave Insurance (FAMLI)

Employer: Colorado State University
Address: 6004 Campus Delivery
555 South Howes St, 2nd Floor
Fort Collins, CO 80523-6004

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 patient (☐ was / ☐ is/ ☐ will be) seen on the following date(s):
_____
- 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.)*

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Employee's Name	Date of Birth

Section 2: For Completion by the Treating Health Care Provider (continued)

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☐ **Pregnancy:** The health condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy)

- Is this a pregnancy or childbirth complication? □ Yes □ No

☐ **Chronic Health Conditions:** *(e.g., asthma, migraine headaches)* Treatment visits are expected to be at least twice per year

☐ **Permanent or Long-Term Health Conditions:** Due to the health condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Health Conditions requiring Multiple Treatments:** *(e.g., chemotherapy treatments, restorative surgery, etc.)* Due to the health condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above:** If none of the above six categories is checked, *(i.e., inpatient care, pregnancy)* no additional information is needed. Please sign and date the form.

Date health condition commenced: _____ Date you first examined the patient for this health condition: _____	Last office visit: _____ Next office visit: _____ Provide your best estimate of how long the health condition lasted or will last: _____

For the health condition for which your patient is requesting time away from work, is it your belief that the health condition was caused by or otherwise related to a workplace injury or illness?
□ Yes
□ No

If the employer does not supply a statement of your patient's essential functions or a job description, answer these questions based upon the patient's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).

Due to the health condition, my patient (□ was not able / □is not able / □will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function your patient was/is/will be unable to perform.

Provide the relevant medical facts relating to the health condition requiring this leave (these facts may include diagnosis, symptoms, or any regimen of continuing treatment such as the use of specialized equipment):

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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**

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 the Employee

Address, City, State, Zip Code

Cell Number	Home 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:	Email Address:

Treating Health Care Provider Signature: **Date:**