Health Care Provider Certification

Family Member's 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
Fax: 970-491-6302
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 the process, complete **Sections 1 and 2**, and send it to your family member's treating healthcare provider to complete **Section 3** and return to us with your Application and any other supporting documents as part of your claim for benefits.

Section 1: Employee Information

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: About the Family Member

Select the family member to you. The family member is your:

☐ Child (of any age) ☐ Spouse ☐ Domestic Partner ☐ Civil Union Partner
☐ Parent or your Spouse/Domestic Partner's Parent
☐ Grandparent or your Spouse/Domestic Partner's Grandparent
☐ Grandchild
☐ Sibling or Spouse's Sibling
☐ Person with whom the employee has a significant bond that is or is like a family relationship

Relationships include "biological, foster, adoptive, step, and *in loco parentis* relationships and the same relationships to the employee's spouse or domestic partner, if applicable.

First Name	Last Name	Date of Birth

Address, City, State, Zip Code

Section 3: For Completion by the Family Member's Treating Health Care Provider

A family member of your patient has made a request to be absent from work to care for your patient. For us to make a decision on the employee's claim for CO FAMLI benefits for the care of your patient, we will need you to complete the information in Section 3. When completing this certification, we ask:

- Your answers are to your best estimate based on your medical knowledge, experience, and examination of your 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 patient's health condition for which the employee is seeking benefits.
- 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).

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Employee's Name	Date of Birth

Section 3: For Completion by the Family Member's Treating Health Care Provider (continued)

Patient's Name: _____

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Check the box(es) for the questions below, as applicable.

☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to 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 health condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than three consecutive, full calendar days.*
- The patient (☐ was / ☐ will be) seen on the following date(s): _____
- The health condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g., prescription medication (other than over the counter) or therapy requiring special equipment)*

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

☐ **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)* 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, *(e.g., 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: _____

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):

To qualify for benefits, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

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Employee's Name	Date of Birth

Section 3: For Completion by the Family Member's 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 employee will need to care for your patient.

☐ **Continuous leave**

Due to the health condition and associated treatment and recovery, it was/is/will be necessary for the employee to be absent from work to provide care for my patient for the continuous period beginning ____/____/_____ and ending ____/____/_____.

☐ **Reduced Work Schedule**

Due to the health condition and associated treatment and recovery, it was/is/will be necessary for the employee to be absent from work to provide care for my patient beginning ____/____/_____ and ending ____/____/_____.

It is necessary for the employee to provide care for my patient for _____ hours per week.

☐ **Intermittent leave:**

Due to the health condition, my patient is expected to have periodic flare-ups or follow-up treatment appointments and it was/is/will be necessary for the employee to be absent from work to provide care for my patient beginning ____/____/_____ and ending _____/_____/_____.

It is necessary for the employee to provide care for my patient for _____ hours per week.

Treating 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:**