GRAND VALLEY STATE UNIVERSITY

HUMAN RESOURCES
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Staff Member's Responsibilities Sheet for University Medical and FMLA Leave

A. Application

1. Go to www.gvsu.edu/hro and select Forms/Benefits/ Other Forms/University Medical and FMLA Leave Application-Faculty/Salaried Staff.
2. Actual medical facts must be stated or described on the form to support the need for leave.
3. Vague and ambiguous information and/or unanswered questions could render the form incomplete and insufficient and could result in the form being returned to the staff member.
4. The form should be submitted to Human Resources as far in advance of the leave as possible.
5. Staff member is responsible for ensuring the treating physician completes the form in its entirety.
6. A staff member requesting medical leave is automatically reviewed for FMLA coverage. Where applicable medical and FMLA leave will be processed concurrently.

B. Communication with Human Resources

1. HR Contact: Natalie Trent, Human Resources Representative, P: (616)-331-2215, Fax: 616-331-9365; trentnat@gvsu.edu
2. It is the staff member's responsibility to follow all directions or requests from the Human Resources Representative.
3. It is the staff member's responsibility to speak directly with the Human Resources Representative via phone, in person, or e-mail. Voicemail is acceptable to request a return call.

C. Communication with Supervisor

1. It is the staff member's responsibility to update his/her supervisor regarding changes in return dates, work restrictions, or returns that result in less than a full-time work schedule if applicable.

Failure to follow these instructions could result in denial or interruption of leave

Application/Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act and University Medical Leave)

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations. Employers must generally maintain records and documents relating to medical certifications, recertification's, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

Employer name and contact: Grand Valley State University, Natalie Trent, P: (616) 331-2215, F: (616) 331-9365

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions:

_____

_____

_____

_____

Check if job description is attached: ☐

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave and/or University Medical Leave due to your own serious health condition. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA and/or University Medical Leave request.

It is mandatory to complete each question in order to process the leave accurately.

Staff Member's Name:	
Staff Member's G#:	
Staff Member's Mailing Address:	
Staff Member's Phone Number:	
Actual/Estimated Last Day of Work:	

Signature: _____ Date: _____

Authorization to Release Information. I hereby authorize my Physician(s) to release any information acquired in the course of my examination or treatment, but limited to the condition described on this form.

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA and/or University Medical Leave. 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 to determine FMLA and/or University Medical Leave coverage.** Limit your responses to the condition for which the employee is seeking leave. **Please be sure to sign the form on page three.**

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____Fax: (_____)_____

PART A: MEDICAL FACTS

1. Nature of illness/injury/condition and/or name of surgical procedure: _____

   _____

2. 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:

   _____

3. Is the medical condition pregnancy? ☐ No ☐ Yes. If so, expected delivery date: _____

4. Use the information provided by the employer in Section I to answer this question. If the employer does not 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 functions.

   Is the employee unable to perform any of his/her job functions due to the condition? ☐ No ☐ Yes.

   Identify the job functions the employee is unable to perform:

   _____

5. 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):

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

6. 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: _____

7. 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 _____

8. 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):

   How many episodes/occurrences: _____

   Lasting for how long: _____ day(s) _____ week(s) _____ month(s)

_____ _____

Signature of Health Care Provider **Date**

ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

_____

_____

Additional space if needed.