Certification of Health Care Provider for Family Member's Serious Health Condition

SECTION I: For Completion by Sodexo

Sodexo contact information: Jennifer McLeod (Name) 270-745-2290 (Phone number)

Email: jennifer.mcleod@wku.edu Fax number: 270-745-6458

Employee's Job Title: Environmental Services Attendant

Employee's Regular Job Schedule: 4 am-12pm 5pm-1am 9pm-5am

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 or Sodexo's FMLA-Like or Non FMLA Leaves offered under company policy permits Sodexo to require that you submit a timely, complete, and sufficient medical certification to support a request for leave under the FMLA or Sodexo's FMLA-Like or Non-FMLA leaves under company policy to care for a covered family member with a serious health condition. Your response is required to obtain or retain the protections of FMLA or Sodexo's Non-FMLA under company policy. Failure to provide a complete and sufficient medical certification may result in a denial of your leave request. You have 15 calendar days to return this form completed to Sodexo.

Your name: _____
First Middle Last

Contact: _____
Home# Cell# Email

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

If family member is your son or daughter, provide his/her date of birth: _____

Describe the care you will provide to your family member and estimate the length of leave needed to provide such care:

_____

_____

_____

_____

Employee Signature: _____ Date: _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA or Sodexo's Non-FMLA policy to care for your patient. This Medical Certification Form is required for approval of the request for leave. Please 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. Please be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine coverage under the FMLA or Sodexo's Non-FMLA-Like under company policy. Limit your responses to the condition for which the employee is seeking leave to care for your patient. Do not provide any "genetic information" as defined by the Genetic Information Nondiscrimination Act of 2008 (GINA). Page 4 provides space for additional information, should you need it. Please be sure to sign and date the form on the last page.

Name of Patient: _____

Provider's name: _____

Type of practice / Medical specialty:_____

Business Address: _____

Telephone: (_____)_____ Fax: (_____)_____

Email: _____

PART A: MEDICAL FACTS

1. Approximate date condition began:_____
2. Probable duration of condition:_____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ☐ No ☐ Yes If yes, dates of admission:_____

4. Date(s) you treated the patient for the condition:_____
5. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes
6. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes
7. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g.,physical therapist)? ☐ No ☐ Yes If yes, state the nature of such treatments and expected duration of t reatment:

   _____

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

9. Describe the relevant medical facts related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment by you or another health care provider such as the use of specialized equipment):

_____

_____

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

2. Estimate the beginning and ending dates for the period of incapacity: _____

3. During this time, will the patient need care? ☐ No ☐ Yes

4. Explain the care needed by the patient and why such care is medically necessary:

_____

_____

_____

_____

_____

5. Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes

6. Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

_____

Explain the care needed by the patient, and why such care is medically necessary:

_____

_____

8. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
☐ No ☐ Yes

9. If absences for the treatment of the patient will be intermittent, how long will the employee need to be absent to care for the patient for each treatment, including any necessary recovery period: _____hour(s) _____ day(s) for each treatment.

10. If the employee needs a part-time or reduced schedule to care for the patient during treatment, provide details regarding the employee's schedule:

The employee can work _____ hour(s) per day, _____ day(s) per week from _____ (date) through _____ (date).

11. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ Yes

12. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and 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: _____ episodes every _____week(s) or _____ month(s)

Duration: _____ hour(s) or _____ day(s) per episode

13. Does the patient need care during these flare-ups? ☐ No ☐ Yes

14. Explain the care needed by the patient, and why such care is medically necessary:

_____
_____
_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____
_____
_____
_____
_____

_____ _____
Signature of Health Care Provider Date