Certification of Health Care Provider for Employee's Serious Health Condition

SECTION I: For Completion by SODEXO

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

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

Attach job description (check if attached) ☐ or list employee's essential job functions:

Custodial/Janitorial Work

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

Your name: _____
First Middle Last

Contact: _____
Home# Cell# Email

SECTION III: For Completion by the Health Care Provider

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient, a Sodexo employee, has requested leave under the FMLA or Sodexo's FMLA-LIKE or Non-FMLA leaves offered under company policy. This Medical Certification is required. 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 coverage under FMLA or Sodexo's FMLA-Like or Non-FMLA leaves offered under company policy. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members. Please be sure to sign and date the form on the last page.

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 so, dates of admission: _____

4. Date(s) you treated the patient for 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 so, state the nature of such treatments and expected duration of treatment:

_____

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

9. Use the information provided by Sodexo in Section I to answer this next question (job description or list of essential functions). If that information was not provided, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to t he condition: ☐ No ☐ Yes
If so, identify the job functions the employee is unable to perform:

_____

10. Describe the relevant medical facts related to the condition for which the employee seeks leave (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 AND TYPE OF LEAVE NEEDED

1. What type of leave does the employee need for his/her own serious health condition?

☐ Single continuous period of leave
Provide the beginning and ending dates for the period of absence:

_____

☐ Intermittent leave or reduced schedule

2. If intermittent leave or a reduced schedule is medically necessary for treatment, please answer the following:

   a. Estimate the treatment schedule, including the dates of any scheduled appointments

   _____

   b. If absences for treatment will be intermittent, how long will the employee need to be absent for each treatment, including any recovery period: _____ hour(s) _____ day(s) for each treatment.

   c. If the employee needs a part-time or reduced work schedule for his own treatment, provide details regarding the employee's schedule:

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

3. If intermittent leave or a reduced schedule is medically necessary for episodic flare-ups associated with the condition, please answer the following:

   a. 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):

   Frequency: _____episode(s) every _____ week(s) or_____month(s)

   Duration:_____hour(s) or _____day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

Signature of Health Care Provider: _____ **Date**: _____

Printed Name of Health Care Provider: _____