



For Completion by Employee: This form must be completed in its entirety by your family member's healthcare provider and returned to HR within 15 calendar days. Failure to provide a complete and sufficient medical certification may result in the delay or denial of your FMLA request. By submitting this form to their healthcare provider, your family member authorizes that provider to release the completed form to the administrators of the Family and Medical Leave Act at the University of Texas at Austin.

1. UT Austin Employee's Name & EID: 2. Patient's Name: 3. Date: 4. Patient's Relationship to UT Austin employee: 5. Briefly describe the care you will provide to your family member: (check all that apply)

For Completion by the Health Care Provider: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

6. Covered Condition(s) - Describe the medical facts related to the condition(s) of the patient in Box 2 that require the employee in Box 1 to be off work continuously or intermittently in order to care for them (such facts may include symptoms, diagnosis, or any regimen of continuing treatment):

7. Estimated Duration of Patient's Condition(s): 8. Approximate date patient's condition started or will start: 9. Date employee's leave should begin:

10. Eligibility for Leave - Please check each statement that applies to the patient listed in Box 2. Incapacity Plus Treatment, Inpatient Care, Chronic Conditions, Permanent or Long Term Conditions, Conditions Requiring Multiple Treatments, Pregnancy, None of the above.

11. Need for Leave - Please provide your best estimate when answering the questions for each specific scenario. Continuous Leave, Intermittent Leave.

Healthcare Provider Signature, SUBMIT FORM TO: HR - Benefits & Leave, Secure eFax: (512) 471-7008, NEED HELP? HR - Benefits & Leave, Phone: (512) 475-8099, HRS-LM@austin.utexas.edu

Healthcare Provider Printed Name, Date, Type of Practice / Medical Specialty