LSU | Office of Human Resource Management

CERTIFICATION OF PHYSICIAN OR PRACTITIONER
FAMILY MEDICAL LEAVE ACT OF 1993

Section I

Employee's Name: _____ LSU ID: _____

Employee's Address: _____ Home Phone: _____

Is your position currently grant funded? Yes No [If you are grant funded, your supervisor must notify Sponsored Program Accounting]

Are you currently a tenure-track faculty member? *[If you have already obtained tenure, check "no."]* Yes No

Prefer the response by email? Yes No Email address: _____

Employee's Supervisor's Name: _____

Patient's Name *[If other than employee]*: _____

Patient's Relationship to Employee *[If child, please state age]*: _____

Section II

Diagnosis/Reason for Request: _____

Date condition commenced: _____

Probable duration of condition: _____

Continuous Absence Intermittent Absence

Section III

Regimen of treatment to be prescribed. *[Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.]*

By Physician or Practitioner: _____

_____

_____

By another provider of health services, if referred by a Physician or Practitioner: _____

_____

_____

Section IV

If this certification relates to care for the employee's seriously-ill family member, skip items in section IV and proceed to Section V. Otherwise, continue below.

Check Yes or No in the boxes below, as appropriate.

Yes No

Is inpatient hospitalization of the employee required?

Is employee able to perform work of any kind *[If "no," skip to next item.]*

Is employee able to perform the functions of employee's position? *[Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee*

Section V

For certification relating to care for the employee's seriously-ill family member, complete items in Section V as they apply to the family member then proceed to Section VI.

Check Yes or No in the boxes below, as appropriate.

Yes No

Is inpatient hospitalization of the family member (patient) required?

Does, or will, the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

After review of the employee's signed statement *[at the end of this section]*, is the employee's presence necessary or would it be beneficial for the care of the patient? *[This may include psychological comfort.]*

Estimate the period of time care is needed or the employee's presence would be beneficial. _____

_____

_____

Section VI

This question is to be completed by the employee needing family leave.

When family leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or a reduced leave schedule. _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Section VII

Name of Physician or Practitioner: _____ Date: _____

Address: _____ Phone number: _____

Type of Practice *[field of specialization]*: _____

Signature: _____

_____

Mail or fax to:

Louisiana State University
Office of Human Resource Management
110 Thomas Boyd Hall
Baton Rouge, LA 70803
Attention: LaTausha Duncan
Fax: 225-578-5981