Cornell University

Medical Leaves Administration
East Hill Office Building Suite 130
395 Pine Tree Rd., Ithaca, NY 14850
Tel: (607) 255-5698 Fax: (607) 255-5698
eeg49@cornell.edu www.hr.cornell.edu

Short Term Medical Leave Provider Verification Form

CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S OWN SERIOUS HEALTH CONDITION

Employee Instructions

- Use this form for **Academic Short Term Medical Leave**.
- You must complete, sign, and date Part A.
- Have the Health Care Provider complete and sign Part B.
- You are responsible for returning or ensuring the return of the completed form (Part A and Part B) within 15 days of the eligibility letter.

Part A: To be completed by the Employee

Employee Name: _____

EMPLID: _____

Title: _____

Department: _____

Telephone – Work: _____

Telephone – Home/Cell: _____

Employee's essential job functions: _____

Your signature below indicates that you have read and understand the Leaves for Professors and Academic Staff policy (POLICY 6.2.1) and agree to the leave provisions.

Employee Signature: _____

Date: _____

Cornell University

Medical Leaves Administration
East Hill Office Building Suite 102
395 Pine Tree Rd., Ithaca, NY 14850
Tel: (607) 255-5698 Fax: (607) 255-5698
eeg49@cornell.edu www.hr.cornell.edu

Part B: To be completed by the Health Care Provider

I: Employee's Name: _____

i. If the employee's condition qualifies under any of the following categories for serious health conditions, please check all applicable categories and provide the supporting medical facts. See the descriptions of these categories on page 4 of this form.

- ☐ (1) Inpatient / Hospital Care
- ☐ (2) Incapacity and Treatment
- ☐ (3) Pregnancy (Incapacity)
- ☐ (4) Chronic Conditions Requiring Treatments
- ☐ (5) Permanent/Long-term Conditions Requiring Supervision
- ☐ (6) Multiple Treatments (Non-Chronic Conditions)

ii. Medical facts that support the category or categories checked:
_____
_____

iii. Date condition commenced: _____

II: Amount of Leave Needed

i- First day employee missed work due to serious health condition: _____
ii- Length of continuous incapacitation: _____
iii- Is employee able to perform any kind of work during the period of incapacitation?

- ☐ Yes
- ☐ No (If 'no', skip to part III)

If yes, please describe:

☐ Reduced Schedule Date reduced schedule to begin: _____

Please indicate the number of hours per day/days per week, etc. that employee may work.
_____

☐ Intermittent Leave Date intermittent schedule to begin: _____

Please describe the schedule and length of time for intermittent leave, as well as the regimen of treatment to be prescribed. Indicate the schedule of visits or treatment, general nature and duration of treatment, including referral to other healthcare providers, 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.
_____
_____

Cornell University

Medical Leaves Administration
East Hill Office Building Suite 102
395 Pine Tree Rd., Ithaca, NY 14850
Tel: (607) 255-5698 Fax: (607) 255-5698
eeg49@cornell.edu www.hr.cornell.edu

II: Amount of Leave Needed (continued from page 2)

iv- Based on the essential functions of the employee's positions (listed on page 1), is the employee able to perform the functions of their position during the period of incapacity?

☐ Yes, they can perform all functions.
☐ No, they cannot perform at least one of the functions. List the functions the employee is unable to perform:

_____
_____

III: Date employee can return to work without restrictions: _____

Health Care Provider Information:

Health Care Provider's Name: _____

Type of practice/medical specialty: _____

Telephone: _____ Fax Number: _____

Signature of Health Care Provider: _____

Date: _____

Cornell University

Medical Leaves Administration
East Hill Office Building Suite 102
395 Pine Tree Rd., Ithaca, NY 14850
Tel: (607) 255-5698 Fax: (607) 255-5698
eeg49@cornell.edu www.hr.cornell.edu

Description of Serious Health Condition

§ 825.113 Serious health condition.

(a) For purposes of FMLA, ***serious health condition*** entitling an employee to FMLA leave means an illness, injury, impairment or physical or mental condition that involves inpatient care as defined in § 825.114 or continuing treatment by a health care provider as defined in § 825.115.
(b) The term ***incapacity*** means inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.
(c) The term treatment includes (but is not limited to) examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition (e.g., oxygen). A regimen of continuing treatment that includes the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider, is not, by itself, sufficient to constitute a regimen of continuing treatment for purposes of FMLA leave.

§ 825.114 Inpatient care.

Inpatient care means an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity as defined in § 825.113(b), or any subsequent treatment in connection with such inpatient care.

§ 825.115 Continuing treatment.

A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:
(a) ***Incapacity and treatment.*** A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
(1) Treatment two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
(2) Treatment by a health care provider on at least one occasion, which results in a regimen of continuing treatment under the supervision of the health care provider.
(3) The requirement in paragraphs (a)(1) and (2) of this section for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.
(4) Whether additional treatment visits or a regimen of continuing treatment is necessary within the 30-day period shall be determined by the health care provider.
(5) The term ***extenuating circumstances*** in paragraph (a)(1) of this section means circumstances beyond the employee's control that prevent the follow-up visit from occurring as planned by the health care provider. Whether a given set of circumstances are extenuating depends on the facts. For example, extenuating circumstances exist if a health care provider determines that a second in-person visit is needed within the 30-day period, but the health care provider does not have any available appointments during that time period.
(b) ***Pregnancy or prenatal care.*** Any period of incapacity due to pregnancy, or for prenatal care. *See also* § 825.120.
(c) ***Chronic conditions.*** Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:
(1) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse under direct supervision of a health care provider;
(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
(3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
(d) ***Permanent or long-term conditions.*** A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
(e) ***Conditions requiring multiple treatments.*** Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, for:
(1) Restorative surgery after an accident or other injury; or
(2) A condition that would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) FMLA CERTIFICATION DISCLOSURE

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. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.