THE UNIVERSITY of MISSISSIPPI | Human Resources

UNIVERSITY OF MISSISSIPPI
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# Medical Certification Form

## Medical Leave of Absence, Family and Medical Leave, Donated Leave, Return to Work

Employees must complete the Medical Certification Form when requesting Medical Leave of Absence (LOA), Family and Medical Leave (FML), and/or Donated Leave. The requesting employee must complete Section A. The attending health care provider for the employee or for the employee's immediate family member must complete Sections B, C, and D (as applicable) and sign the bottom of the form. Please refer to the leave information on the University of Mississippi Human Resources Benefits page located at https://hr.olemiss.edu/benefits/leave/ (definitions are included). **Note: Some health care providers may charge a fee to complete this form.**

| **Section A: To be completed by the Employee** | |
|---|---|
| Employee Name: | University ID #: |
| Family Member's Name (if leave is not for employee): | Relationship to Employee: |
| Mailing Address: | Primary Phone #: |
| Types of leave requested (Check all that apply):<br>☐ Medical Leave of Absence ☐ FMLA (Section B) ☐ Donated Leave (Section C) ☐ Return to Work Certification (Section D) | |
| Leave Start Date<br>Anticipated Leave End Date | Describe the circumstances for which the leave is being requested: |
| Employee's Signature (or personal representative) ***No digital signatures.*** | Date |

The following sections must be completed by the employee's attending health care provider or family member's attending health care provider. The provider must be certified as defined by state statute.

**Section B: Request for Medical Leave and FMLA (Completed by Certified Medical Care Provider)**

Approximate start date of medical condition or effective date of medical certification: _____

Estimated length of medical condition or projected medical certification end date: _____

**For FMLA Eligibility:** Check any of the following that pertain to the employee or the employee's family member:

- ☐ Incapacity of more than three (3) calendar days for the following.
  - ☐ Treatment two (2) or more times by a health care provider,
  - ☐ Treatment by a health care provider on a least one (1) occasion with prescribed medication,
  - ☐ Treatment by a health care provider on a least one (1) occasion resulting in a regimen of treatment (including prescriptions)
- ☐ Pregnancy – any period of incapacity due to pregnancy or for prenatal care
- ☐ Hospital Care – inpatient (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility
- ☐ Intermittent Incapacity / Chronic Conditions requiring at least two (2) treatments per year
  - ☐ May cause episodic rather than continuing periods of incapacity (i.e., migraine headaches or diabetes)
- ☐ Permanent / Long term Conditions requiring supervision (i.e., Alzheimer's, severe stroke, terminal illness)
- ☐ Multiple Treatments / Non-chronic Conditions (i.e., physical therapy for severe arthritis)
- ☐ None of the above

**Section C: Request for Donated Leave (Completed by Certified Medical Care Provider)**

In accordance with State Code and University Policy, faculty and staff employed one-half time or more, for at least twelve (12) months, and who worked at least 1,250 hours during the twelve (12) months immediately preceding their leave of absence may qualify for donated leave for the following reasons:

- Catastrophic injury or illness – a life-threatening injury or illness of an employee or a member of an employee's immediate family (spouse, parent, stepparent, sibling, child or stepchild) which totally incapacitates the employee from work**.**
- Chronic illnesses or injuries – an illness or injury of an employee or a member of an employee's immediate family (spouse, parent, stepparent, sibling, child, or stepchild) such as cancer or major surgery, which result in intermittent absence from work, are long-term in nature, and require long recuperation periods.

***Note****: Conditions that are short-term in nature, including, but not limited to, common illnesses such as influenza and the measles, and common injuries, are not catastrophic.*

Does the employee meet the "Catastrophic Injury or Illness" or "Chronic Illness or Injury" definition as described above?

**Medical Provider: Please initial the appropriate selection.** _____ Yes _____ No **If yes, please provide the date employee or employee's immediate family member was first diagnosed with catastrophic/chronic illness or injury: _____

Estimated length of catastrophic illness/injury or projected end date: _____

**Section D: Return to Work Certification (Completed by Certified Medical Care Provider)**

☐ Employee may return to work without restrictions on (date) _____

☐ Employee is totally unable to return to work at this time. Patient will be evaluated on (date): _____

☐ The employee may return to work but may miss work intermittently. Estimate the frequency of flare-ups and the duration of related incapacity the patient may have (i.e. 1 episode/appointment every 3 months lasting 1-2 days).

Frequency: _____ times per ☐ week ☐ month Duration: _____ ☐ hour(s) or ☐ day(s) per episode

☐ Employee may return to work but may miss work for the follow up doctor's appointment.

Frequency: _____ times per ☐ week ☒ month Duration: _____ ☐ hour(s) or ☐ day(s) per episode

☐ Employee may return to work with restrictions.

☐ Part-time or reduced work schedule is needed at ___ hours per day, ___ days per week from _____ to _____.

☐ The following restrictions are recommended:

| DEGREE OF RESTRICTIONS | Maximum weight allowance |
|---|---|
| ☐ **Sedentary Work**. Lifting 10 lbs. maximum. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary to perform job duties. A job is sedentary if walking and standing are required only occasionally and other sedentary criteria are met.<br>☐ **Light Work.** Lifting 20 lbs. maximum with frequent lifting and/carrying of objects weighing up to 10 lbs. A job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm leg controls.<br>☐ **Medium Work**. Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.<br>☐ **Heavy Work**. Lifting 100 lbs. maximum with frequent lifting and/ carrying of objects weighing up to 50 lbs.<br>☐ **Very Heavy Work**. Lifting objects in excess of 100 lbs. with lifting and/or carrying of objects weighing 50 lbs. or more. | Lifting: _____ lbs.<br>Repetitive Lifting: _____ lbs.<br>Carrying: _____ lbs.<br>Pushing/Pulling: _____ lbs.<br>**Daily restricted time for activity**<br>Walking: _____ hours<br>Standing: _____ hours<br>Sitting: _____ hours<br>Stooping/Bending: _____ hours<br>Kneeling/Crawling: _____ hours<br>Squatting/Crouching: _____ hours<br>Climbing/Balancing: _____ hours |

Other Restrictions:

_____ _____

Signature of Doctor/Health Care Provider Date of Signature

_____ _____

Printed Name and Address of Doctor/Health Care Provider Phone Number