HUMAN RESOURCE SERVICES
NORTHERN ILLINOIS UNIVERSITY

1515 West Lincoln Highway, DeKalb, IL 60115
815/753-1119 FAX 815/753-1001

2006 excellence

Medical Certification

Employee's Name ______________________________

Patient's Name ______________________________ Relationship to Employee __________

The following is to be completed by the Physician/Practitioner ONLY

Serious Illness as defined by the FMLA

(See attached FMLA definition of Serious Illness)

A condition that renders the patient incapable of working. Incapacity under the FMLA is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof or recovery therefrom. If patient's condition qualifies under any of the categories described, please check the applicable category.

____ Hospital Care, Inclusive dates __________
____ Birth of a Child or Adoption
Estimate Date of Birth __________
Anticipated Date of Adoption __________

____ Absence Plus Treatment
____ Permanent/Long Term Condition requiring Supervision
____ Chronic Condition Requiring Treatment
____ Multiple Treatment

Patient Medical Information

Please provide an estimate of time if it is unknown.

Date current medical condition resulted in loss time. ______________________________
Probable duration of the condition. ______________________________
Probable duration the patient is **continuously** incapacitated. (must have begin and end date even if only estimated)
Beginning ______________________________ Ending: ______________________________
Reduced Schedule: (must have begin and end date even if onle estimation)
Beginning ______________________________ Ending: ______________________________
Reduced Schedule, please provide number of days per week and duration in which employee is able to work, (e.g. 3 days per week, not consecutive days, up to 4 hours in duration).

____
____

Intermittent: (must have begin and end date even if only estimation)
Beginning ______________________________ Ending: ______________________________
Intermittent, please describe the frequency and duration of intermittent leave.

____
____
____

Can treatment occur after work hours? If no, Why?(Be specific)

____
____

Medical Facts

Describe the **medical facts** which support your medical opinion.

____
____
____

Complete for Chronic Condition ONLY

Continuously incapacitated YES NO

If not continuous, frequency of episodes of incapacity ____________________

Duration of loss time per episode ____________________

Regimen of Treatment

Please provide a general description of treatment under your supervision.

____

____

If treatment will be provide by another health provider, please state the nature of the treatment.

____

____

Medical Leave for Employee's own medical condition

Is the employee (patient) unable to perform the essential duties of their position? Please provide details.

____

____

If the employee requires work modification due to personal medical condition, please provide detailed description of work restrictions.

Physical Restrictions

Example : 25 lbs. weight 20 x per day frequency Up to 10 minutes duration

Sit ____________ frequency ____________ duration
Standing ____________ frequency ____________ duration
Walking ____________ frequency ____________ duration
Climbing ____________ frequency ____________ duration
Pushing/Pulling ____________ weight ____________ frequency ____________ duration
Lifting/Carrying ____________ weight ____________ frequency ____________ duration

Medical Leave for a Family Member's medical condition - spouse, child, parent

The patient does or will require assistance for basic medical or personal needs, hygiene, nutritional needs safety or transportation. YES NO

If no, would the NIU employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient recovery? YES NO

Physician or Practitioner's Information

Name: ____________________
Address: ____________________
City ____________ State ____________ Zip ____________
Telephone Number: ____________ Fax Number: ____________

I, the attending Physician/Practitioner, certify that this information is accurate and is based on my medical opinion.

Signature of Physician/Practitioner: ____________________ Date: ____________