Certification of Health Care Provider for Serious Health Condition (FMLA) – Duke Employee

(Form 1002-E)

Employee Statement

	Last Name	Duke Unique ID	Best Phone No.	Shift (Days/Nights/Weekends)
Supervisor Name	Supervisor Phone	Supervisor Emai	I	Supervisor Fax
clarification or auther	Occupational Health & Wellness, stication of any of the information ication for the purpose of clarificat	n below. I also authorize	e my health care provider	to disclose the health informatio
Employee Signature			Date	
Health Care Prov	vider Statement			
	e has requested leave under andition for which the employee			uestions below and limit you
Health Care Provide	r's Name (Please Print)	_	Type of Practice	
Telephone No.	E-mail		Fax No.	
ndividual or family mem	etic information Nondiscrimination A ber of the individual, except as specific	cally allowed by this law. To	comply with this law, we are a	sking that you not provide any genet
individual or family mem information when respon the result of an individua	ber of the individual, except as specific ding to this request for medical inforn I's or family member's genetic test, the fetus carried by an individual or an inc	cally allowed by this law. To mation. "Genetic information e fact that an individual or a	comply with this law, we are a n" as defined by GINA, includes n individual's family member s	sking that you not provide any genet an individual's family medical histor ought or received genetic services, an
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Er	nployee Name:	Duke Unique ID:	(FORM 1002-E)	
8. Please describe other relevant medical facts related to the condition for which the employee needs leave (s may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized eq				
<u>A</u>	mount of Leave Needed			
9.		s/her job functions* due to his/her condition? job functions or, if not provided, after discussing with the employee e is unable to perform:	☐ Yes ☐ No	
	Indicate whether inability is: continuous of	or \square episodic		
10). Was the employee or will the employee be in	ncapacitated for a single continuous period of time, including time	e for treatment	
	and/or recovery?		☐ Yes ☐ No	
	If yes, estimate the beginning and ending dat	tes for the period of incapacity:		
	Begin date Date	e employee can return to work		
11	. Is it <i>medically necessary</i> for the employee to	have follow-up treatments/appointments for this condition?	☐ Yes ☐ No	
	If yes, estimate the treatment schedule:			
12	2. Is it <i>medically necessary</i> for the employee to	work part-time or on a reduced schedule because of this condit		
	If yes, estimate part-time/reduced schedule:		☐ Yes ☐ No	
	hour(s) per day; day(s) per week fr	om through		
13	3. Will the condition cause episodic flare-ups pr	reventing the employee from performing his/her job functions?	\square Yes \square No	
14	I. Is it <i>medically necessary</i> for the employee to	be absent from work during the flare-ups?	☐ Yes ☐ No	
	If yes, please explain:			
15	5. Are there job modifications that could be imp	plemented during flare-ups to allow the employee to remain at		
	If yes, please list:		☐ Yes ☐ No	
16		and your knowledge of the medical condition, please estimate \boldsymbol{bc} pacity that the employee may have over the next 6 months (e.g.		
	**While it may be difficult to answer this question p information is not provided, the default frequency will	precisely, please give your best estimate of the frequency and duration of t be 4 times per year for 1 day.	he flare-ups. If this	
	Frequency: times per week(s)	month(s)		
	Duration per episode: hour(s) or c	day(s)		
A	dditional information related to question	(s) above (please indicate question number):		
_				
 He	ealth Care Provider Signature	 		

Health Care Provider: Return completed form to employee