UCONN
UNIVERSITY OF CONNECTICUT

DEPARTMENT OF HUMAN RESOURCES
9 Walters Avenue
Storrs, CT 06269-5075
(860) 486-3034 (p) (860) 486-0406 (f)

MEDICAL CERTIFICATE

(to be used by Graduate Assistants who will be absent for a personal illness /injury, maternity or an immediate family member's illness/injury)

GRADUATE ASSISTANT INFORMATION					
Graduate Assistant Name:		Employee No.:			
Street Address:					
City:		State:		Zip Code:	
PATIENT INFORMATION					
Patient Name:					
Relationship to Graduate Assistant:	❑ Self	❑ Spouse/Registered Domestic Partner			
	❑ Child	❑ Parent			
	❑ Parent-in-law				

TO BE COMPLETED BY PHYSICIAN

CONDITIONS GOVERNING ISSUANCE

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.

Please answer the following:		
Date of the patient's most recent examination for the condition.	Date:	
The approximate date the condition commenced.	Date:	
The probable duration of the patient's present incapacity. If unknown, please indicate date of the next appointment.		

If the graduate assistant is the patient, s/he will be able to return to ❑ **regular** or ❑ **selective work** on_____ (*date)*.
If selective work, explain below.

Please check the box below that best describes the patient's condition.	
❑	**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: • Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, **OR** • 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. • Treatment means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within **seven** (7) days of the first day of incapacity.
❑	**Pregnancy:** Any period of incapacity due to pregnancy, or for prenatal care.
❑	**Chronic Conditions Requiring Treatments:** Any period of incapacity or treatment for such incapacity due to a chronic condition which: • Requires periodic visits for treatment by a health care provider or by a nurse physician's assistant under direct supervision of health care provider; • Continues over an extended period of time (including recurring episodes of a single underlying condition); **AND** • May cause episodic rather than a continuing period of incapacity. **Examples**: *asthma, diabetes, epilepsy*.
❑	**Permanent/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**: *Alzheimer's, a severe stroke, or the terminal stages of a disease*.
❑	**Multiple Treatments (Non-Chronic Conditions):** 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, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment. **Examples**: *cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), and kidney disease (dialysis).*
❑	**None of the Above**

Please include a brief statement that describes the medical facts used in support of your above certification: If leave is due to the birth of a child, please provide delivery date and delivery type:

Name of Physician or Practitioner:					
License Number:		Phone:			
Address:					
City:		State:		Zip Code:	
Signed *(Physician or Practitioner)*:		Date:			

Please return completed form to: University of Connecticut, Attention: Megan Stimson - Human Resources, 9 Walters Avenue, Storrs, CT 06269-5075 or via Fax (860) 486-0406. If you have questions completing the form, contact Megan Stimson at megan.stimson@uconn.edu or by phone at (860) 486-0408.