HIPAA AUTHORIZATION
NORTHERN MICHIGAN UNIVERSITY
CERTIFICATION OF HEALTH CARE PROVIDER

Employee Name:_____ **Department:** _____

Date(s) of Absence From:_____ **Through:**_____ **Total Hours Used:**_____

I hereby authorize and direct my health care provider to complete the following information after which I will present this form to the Director of Human Resources, or the Director's designee, at the Human Resources Department.

Employee Signature:_____ **Date**:_____

I certify that the above patient was unable to work because of a **Serious Health Condition.** For Northern Michigan University's purposes, a **Serious Health Condition** means an illness, injury, incapacity due to pregnancy, impairment, or a physical or mental condition that involves one of the following **(CIRCLE ONE)**:

a. Inpatient Hospital Care including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

b. A period of incapacity of more than three (3) consecutive calendar days that also involves treatment two (2) or more times by a health care provider, 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.

c. A chronic condition which requires periodic visits for treatment by a health care provider which continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.

d. Other (describe below)

e. None of the above

Describe the medical facts which support your certification: Please note the Genetic 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 of 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 and 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.

_____

_____

State the approximate date the condition commenced, and the probable duration of the condition:

_____

Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition?_____ **If yes, the probable duration:** _____

_____

If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

_____

If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

_____

_____ _____

(Name and Signature of Health Care Provider) **Date of Certification**

Employee should return the completed form to Kimberly Hongisto, Benefits Assistant
Fax: (906) 227-2334

February 2015