# Provider Certification for Family and Medical Leave

UMKC School of Medicine

Student Name ___________________________________________ Student ID: ____________________________

*My signature below authorizes my care provider to complete and submit this form to the UMKC Council on Evaluation*

Student/Patient Signature ___________________________________________

Provider Directions: Please review the UMKC School of Medicine Technical Standards document provided by the student/patient and then complete this form as indicated for the student/patient listed above. Review of the Technical Standards is not required for a patient that is not a student at the UMKC School of Medicine Completed forms can be returned directly to the student/patient or submitted directly to the UMKC School of Medicine's Council on Evaluation. Forms may be emailed to Connor Fender at fenderco@umkc.edu. Please contact the Council on Evaluation at 816.235.2171 with questions.

Provider Name __________________________________________ Medical Specialty ____________________________

Address: __________________________________________ Phone _____________________________

__________________________________________

__________________________________________

Approximate date condition commenced________________

Was the student/patient admitted for an overnight stay in a hospital or residential medical care facility? ______________________

If yes, please provide dates of admission ___________________________________

Date of provider's assessment of student/patient ______________________________________

Will you continue to provide ongoing care for this student/patient? No Yes

Estimate the beginning and end dates of Family and Medical leave for this student ____________________

By signature below, the provider certifies the following:

- I am not an emergency department or urgent care provider for the student/patient at this time.
- I am the treating provider for this student/patient during the Family and Medical leave of absence.
- I am not related to this student in any way.
- I, if applicable, reviewed the UMKC School of Medicine Technical Standards and believe the student is unable to comply with them at this time.
- I saw and evaluated the student/patient in person or via Telehealth and recommended a Family and Medical leave of absence.

_____________________________________ _____________________________________

Provider Signature Provider Name