FMLA LEAVE CERTIFICATION OF HEALTH CARE PROVIDER

(Must be completed and signed by Health Care provider)

1. Name of Person requesting Leave & SSN (First Name, Middle Initial, Last Name - SSN):	2. Name of PATIENT :	2b. Relationship of Patient to Employee: ☐Self ☐Parent ☐Spouse ☐Partner ☐ Dependent Child ☐ (Age of Child)
Dept:	Supervisor and Phone Number:	

3. Circle/Check the appropriate FMLA category: a. ☐Hospital Care b. ☐Absence Plus Treatment c. ☐Pregnancy d. ☐Chronic Conditions Requiring Treatment e. ☐Permanent/Long-term Conditions Requiring Treatment f. ☐Multiple Treatments (Non-Chronic Conditions)	*4.Diagnosis/Medical Facts: (What are the medical facts that support the patient's serious health condition?)
5a. Onset and duration of condition:	5b. Date(s) of patient's present incapacity (if different from 5a):

➲*6.NOTE: Please indicate type of leave requested:

[ ] Continuous: give duration of time off work:_____

[ ] Intermittent: please estimate episodic leave based upon patient's past history:

Frequency of illness episodes:_____

Duration of illness episodes:_____

7. Prescribed treatment regimen and schedule:

[ ] Office visits: #_____per_____

[ ] Therapy visits: #_____per_____

[ ] Prescription medication:_____

[ ] Referral to other providers (who)_____

[ ] Surgery (date):_____

[ ] Procedure (type/date):_____

[ ] Other treatments (type/dates):_____

_____

EMPLOYEE'S OWN SERIOUS HEALTH CONDITION:

8. Is in-patient hospitalization of the employee required? [ ] No [ ] Yes (give dates)_____	9. Is employee able to perform work of any kind? (If "No", skip Item 10.) [ ] Yes [ ] No

10a. Is employee able to perform the functions of employee's position? [ ] Yes [ ] No

10b. If not, please describe employee's restrictions and their duration:

Restrictions (include need for reduced work schedule): _____

FAMILY MEMBER'S SERIOUS HEALTH CONDITION:

11. Will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
[ ] Yes [ ] No

12. After review of the employee's signed statement (see Item 14 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
[ ] Yes [ ] No

13. Estimate the period of time care is needed or the employee's presence would be beneficial to care for the patient.

14. To be completed by the Person Needing Family Leave (Please attach information if applicable)

When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.

Signature of Faculty/Staff: Work #: Home #: Date:

15. Type of Practice (Field of specialization, if any): Print name of Health Care Provider:	Address of Health Care Provider: Office Telephone #:
* Health Care Provider Signature:	Date Signed:

* Required field for consideration.