

HEALTH CARE PROVIDER CERTIFICATION OF EMPLOYEE'S FAMILY MEMBER SERIOUS ILLNESS - FMLA

Employee's name							
Patient's name							
Relationship to employee		Spouse	Parent	Child	(under age 18 or if older and incapable of self care due to a mental or physical disability)		
Description of serious health condition <i>(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.</i>							
(1)	(2)	(3)	(4)	(5)	(6)	None of the above	
Describe the medical facts and/or treatment that meet the criteria of the category checked above (Medical diagnosis/prognosis is not required).							
Date condition commenced: _____ Probable duration of condition: _____							
Probable duration of present Incapacity (if different): _____							
Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?						Yes	No
If no, would the employee's presence to provide psychological comfort be beneficial to the patient's recovery? _____							
Note the probable duration of the need. _____							
Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment of the family member's serious health condition (e.g. follow-up treatment)?							
						Yes	No
If so, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:							
Dates: _____							
Duration: _____ hour(s) or _____ day(s) per episode.							
Period of Recovery: _____							
Will the employee require leave on an Intermittent or reduced schedule basis for the family member's serious health condition, that may result in unforeseeable episodes of incapacity (e.g. flare ups)?							
						Yes	No
If so, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):							
Frequency: _____ times per _____ week(s).							
Duration: _____ hour(s) or _____ month(s): _____							
_____ day(s) per episode.							
If the employee requires leave on an Intermittent or reduced schedule basis to care for a covered family member with a serious Health condition, briefly explain why such care is medically necessary (this can include assisting in the family member's recovery).							
Health Care Provider's Name (Please print): _____							
Health Care Provider's Signature: _____						Date: _____	
Address: _____							
Phone number: _____				Fax number: _____			
Specialty/Type of Practice: _____							