FAMILY AND MEDICAL LEAVE CERTIFICATION FORM
FAMILY MEMBER

For Completion by the EMPLOYER

Employer name and contact _____

For Completion by the EMPLOYEE

Your name:

_____

First Middle Last

Name of family member for whom you will provide care:_____

First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____
_____
_____
_____

_____

Employee Signature Date

For Completion by the HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all questions below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs care. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

Does _____ have a serious health condition? ____Yes ____No
(A **serious health condition** is a disabling physical or mental illness, injury, impairment or condition involving either inpatient care in a hospital, or outpatient care that requires continuing treatment or supervision by a health care provider.)

Approximate date condition commenced: _____

Probable duration of condition: _____

Please provide a brief statement of the course of treatment prescribed by you, including an estimate of the number of office visits, and the nature, frequency and duration of treatment (diagnosis not required):
_____
_____
_____
_____
_____
_____.

Is inpatient hospitalization is required? _____Yes _____No

Explain the care needed by the patient, and why such care is medically necessary:

_____
_____
_____
_____
_____

_____ _____
Signature of Health Care Provider **Date**