Human Resource Services

Certification of Physician

1.	Employee's Name:		SSN:	
2.	Patient's Name (if other than employee):			
3.	Date Condition Commenced:			
4.	Probable Duration of Condition:	Beginning Date:	End Date:	Return to Work:

5. Regimen of Treatment to be Prescribed: (Indicate number of visits, general nature, and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)

a. By Physician or Practitioner:

b. By Another Provider of Health Services, if Referred by Physician or Practitioner:

c. Physician: Please indicate if this is a serious health condition which qualifies for the Family Medical Leave Act (FMLA):

IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 6, 7, AND 8 AND PROCEED TO ITEMS 9 THROUGH 11 ON THIS PAGE AND ITEMS 12 THROUGH 16 ON THE SECOND PAGE. OTHERWISE, CONTINUE BELOW.

6.	☐ Yes	☐ No	Is inpatient hospitalization of the employee required?
7.	☐ Yes	☐ No	Is employee able to perform work of any kind? (If "No," skip item 11.)
8.	☐ Yes	☐ No	Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position or, if none provided, after discussing with employee.)

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEMS 9 THROUGH 11 BELOW AS THEY APPLY TO THE FAMILY MEMBER AND PROCEED TO ITEMS 12 THROUGH 16 ON THE SECOND PAGE.

9.	Relationship to Employee:	☐ Spouse ☐ Child ☐ Parent ☐ Registered Domestic Partner	
10.	☐ Yes	☐ No	Is inpatient hospitalization of the family member (patient) required?
11.	☐ Yes	☐ No	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

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12.	☐ Yes ☐ No	After review of the employee's signed statement (see item 17 below), is the employee's presence necessary, or would it be beneficial for the care of the patient? (This may include psychological comfort.)

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

14. Signature of Physician or Practitioner:

15. Date: Phone:

16. Type of Practice: (Field of specialization, if any)

ITEM 17 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

17. 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:

Employee Signature:

Date:

SSN:

School:

Position:

Phone:

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