

Certification of Physician or Practitioner
(Family and Medical Leave Act of 1993)

1. Employee's Name: _____
2. Patient's Name (If other than employee): _____
3. Diagnosis: _____
4. Date condition commenced: _____ 5. Probable duration of condition: _____
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:

If this certification relates to care for the employee's seriously ill family member, skip items 7, 8 and 9 and proceed to items 10 through 14. Otherwise,

Check Yes or No below, as appropriate.

7. ____ Yes ____ No Is inpatient hospitalization of the employee required?
8. ____ Yes ____ No Is employee able to perform work of an kind? (If "No" skip item 9)
9. ____ 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 of the employee's seriously ill family member, complete items 10 through 14 as they apply to the family member and proceed to item 15.

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?
12. ____ Yes ____ No After review of 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.)
13. Estimate the period of time care is needed or the employee's presence would be beneficial:

Item 14 is to be completed by the employee needing Family Leave

14. 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: _____

15. Signature of Physician or Practitioner: _____

16. Date: _____

17. Type of Practice (Field of Specialization, if any): _____
