



Certification of Health Care Provider

Employee's Name: _____

Patient's name: _____

Date Condition Commenced: _____

Duration of Condition: _____

Personal Health Condition/Child birth

Regimen of treatment to be prescribed:

Number of visits _____

Inpatient care _____

General nature of illness

Is the employee able to perform work of any type?

Serious Health Condition of Family Member

Is inpatient care required?

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

After review of the employee's signed statement (below) is the employee's presence necessary or would it be beneficial for the care of the patient?

Estimate the period of time needed for care or assistance by the employee?

Employee Statement

When family leave is needed to care for seriously-ill family member, the employee shall state the care he/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.

Requested Time off:

From _____ to _____

Employee Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Physician Field of specialization:
