# CLASSIFIED EMPLOYEE FAMILY AND MEDICAL LEAVE CERTIFICATION FORM

| 1. Employee's Name | 2. Patient's Name (if other than employee |
|---|---|
| | |

3. Diagnosis

| 4. Date condition commenced | 5. Probable duration of condition |
|---|---|
| | |

6. 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 13 thru 20 on reverse side. Otherwise, continue below.**

Check **Yes** or **No** in the boxes below, as appropriate

7. Is inpatient hospitalization of the employee required? □ Yes □ No

8. Is employee able to perform work of any kind? ( If **"No"**, skip item 9) □ Yes □ No

9. 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) □ Yes □ No

| 10. Signature of Physician or Practitioner | 11. Date | 12. Type of Practice (Field of Specialization, if any) |
|---|---|---|
| | | |

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**For certification relating to care for the employee's seriously ill family member, complete items 13 thru 17 below as they apply to the family member and proceed to item 20.**

13. Is inpatient hospitalization of the family member (patient) required? □ Yes □ No

14. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? □ Yes □ No

15. 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.) □ Yes □ No

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

**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.

| 18. Employee Signature | 19. Date |
|---|---|
| | |

| 20. Signature of Physician or Practitioner | 21. Date | 22. Type of Practice (Field of Specialization, if any) |
|---|---|---|
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