Hazel Crest School District 152 1/2

FMLA CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(Family and Medical Leave Act of 1993)

1. Employee's Name:_____

2. Patient's Name:_____

This Section to be Completed by Physician:

3. Diagnosis:_____

   _____

4. Date condition commended:_____

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 IS RELATED TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, SKIP ITEMS 7, 8, AND 9 AND PROCEED TO ITEM 10. OTHERWISE CONTINUE ON THE NEXT PAGE.

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Check YES or NO below as appropriate.

	YES	NO	
7.	____	____	Is in-patient hospitalization of the patient required?
8.	____	____	Is patient able to perform work of any kind? (If "No", skip Item 9.)
9.	____	____	Is patient able to perform the functions of patient's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)
10.	____	____	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
11.	____	____	After review of the employee's signed statement (see Item 16 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)

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

13. Signature of Physician or Practitioner:_____

14. Date:_____

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

ITEM 16 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

16. When Family Leave is needed to care for a seriously ill family member, the employee will 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 the leave is to be taken intermittently or on a reduced-leave schedule:_____
_____
_____

When Family Leave is desired for the care of a newborn child, the employee will state the length and dates of the time to be taken:_____

Employee Signature:_____ Date:_____

Attach: Employee Job Description