
CERTIFICATION OF PHYSICIAN OR PRACTITIONER

1. EMPLOYEE'S NAME: _____

2. PATIENT'S NAME (IF OTHER THAN EMPLOYEE): _____

3. GENERAL STATEMENT OF CONDITION: _____

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 10 THROUGH 14. OTHERWISE, CONTINUE BELOW. Check **YES** or **NO** in the boxes below, as appropriate:

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Is inpatient hospitalization of the employee required? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Is employee able to perform work of any kind? (If "NO", skip Item 9.) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | 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.) |

15. Signature of Physician or Practitioner: _____ 16. Date: _____

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

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, COMPLETE ITEMS 10 THROUGH 14 BELOW AS THEY APPLY TO THE FAMILY MEMBER AND PROCEED TO ITEM 15 ABOVE.

- | | YES | NO | |
|-----|--------------------------|--------------------------|--|
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Is inpatient hospitalization of the family member (patient) required? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | After review of the 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 of the employee's presence would be beneficial: _____

ITEM 14 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING 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: (Attach additional pages if necessary.)

Employee Signature: _____ Date: _____
