CERTIFICATION OF PHYSICIAN OR OTHER HEALTH CARE PROVIDER

under the Family and Medical Leave Act

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 care 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 other Health Care Provider:

   b. By another provider of health care services, if referred by a Physician or other Health Care Provider:

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 ON REVERSE SIDE. OTHERWISE, CONTINUE BELOW.

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

	Yes	No	
7.	☐	☐	Is inpatient hospitalization of the employee required?
8.	☐	☐	Is employee able to perform work of any kind? (If "No", skip Item 9.)
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.)

15. Signature of Physician or other Health Care Provider:

16. Title of other Health Care Provider, if applicable:

7. Date:

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