# Family Care Leave - Certification of Health Care Provider

Please return the completed certification form to your Human Resources Office within 15 calendar days.

**PART I** is completed by the employee requesting leave.

**PART II** is completed by a health care provider.

## PART 1 – To Be Completed by Employee

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| Employee’s Name (please print): | Department |
| Employee’s Signature | Date |
| Family Care Leave is needed to care for (check one)  Parent  Spouse  Child  Grandparent  Parent-in-law | |
| Employee’s normal work schedule:  Hours per week:  Days of week and shift you are scheduled to work:  Time off requested/needed (dates): | |

## PART I A - To Be Completed by the Employee Needing Leave to Care for a Family Member

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| State the care you will provide and an estimate of the period during which care will be provided.  Employee Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: |

### Definition of Serious Health Condition (adult) and Treatment or Supervision (child)

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| For an adult a Serious Health Condition is defined as:   1. An illness, injury, impairment, or physical or mental condition that involves any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, and any period of incapacity or subsequent treatment or recovery in connection with such inpatient care; 2. Continuing treatment by or under the supervision of a health care provider or a provider of health care services and which includes any period of incapacity (i.e., inability to work, attend school or perform other regular daily activities).   For a child Treatment or Supervision is defined as:   1. Any medical condition requiring treatment or medication that the child cannot self administer; 2. Any medical or mental health condition which would endanger the child's safety or recovery without the presence of a parent or guardian; or 3. Any condition warranting treatment or preventive health care such as physical, dental, optical or immunization services, when a parent must be present to authorize and when sick leave may otherwise be used for the employee's preventive health care |

## Part 2 – To Be Completed by Health Care Provider

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| Employee (Name)        is requesting leave from work for reasons cited in PART 1 of this form. Please provide the information requested below to certify the necessity of the requested leave. Please only provide information relating to the condition for which the employee is requesting leave. |
| Patient Health Condition - Adult  Is the patient’s condition a “serious health condition” as defined on page 2 of this form?  Yes  No |
| Patient Health Condition - Child  Does the child have a health condition that requires “treatment or supervision” as defined on page 2 of this form?  Yes  No |
| Please describe the medical facts that support your certification: |
| Date the patient’s condition commenced: |
| Probable duration of the patient’s condition: |
| Is the patient incapacitated?  Yes  No  If yes, what it the probable duration of the present incapacity? |

### Health Care Provider Information

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| Health Care Provider Name (Please Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: |
| Health Care Provider’s Medical Specialty: |
| Health Care Provider’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: |
| Health Care Provider’s Address: |
| Please Return This Form To: |