FAMILY AND MEDICAL LEAVE ACT (FMLA) CERTIFICATION FORM

Employee's Section

Employee's Name: _____
Banner ID Number: _____
Employee's Department: _____
Patient's Name (if patient is not employee): _____

Medical Release-My signature authorizes the release of any medical information needed by the College of William and Mary and the Virginia Sickness and Disability Program (Reed Group) for the certification of FMLA. I understand that FMLA may be denied if the information is not provided, is unclear or incomplete.

Employee's Signature: _____ Date Signed _____
Patients' Signature _____ Date Signed _____
(if patient is not employee):

Reason for FMLA Leave:

- ☐ Employee's (your) own medical condition.
- ☐ Employee's spouse/parent/dependent medical condition; check one of the following:
  - ○ Employee's Spouse
  - ○ Parent
  - ○ Dependant 18 or over
  - ○ Dependent under 18
  - ○ Birth, Foster Placement/Adoption of a child

Provider's Section

Thank you for completing your patients FMLA Leave Certification. Please retain a copy of this completed form in the event the College or Virginia Sickness and Disability Program (Reed Group) needs to verify its contents. **THIS FORM WILL BE RETURNED IF ALL AREAS ARE NOT COMPLETED IN FULL**.

Employee or Employee's spouse/parent/dependent's medical condition:

1. Length of time your patient has had/will have this condition: ____/____/____To____/____/____
2. This condition is:
   - ☐ Acute (Absence Treatment)
   - ☐ Chronic/Permanent expected frequency of absence
     _____Days per month lasting _____ hours per absence
   - ☐ Pregnancy, EDC Date: ____/____/____
3. Relating to this condition:
   - ☐ Hospitalization: Admit date: ____/____/____ Discharge date: ____/____/____
   - ☐ PT/OT _____ Times per week
   - ☐ Follow up appointment dates: ____/____/____, ____/____/____, ____/____/___
   - ☐ Other treatment: _____
   - □ The employee cannot perform the essential function of his/her job.
4. Medical facts that support this request:_____
_____
_____

Provider Signature: _____Date: _____
Provider Name: _____Tax ID#_____
Provider Address: _____
Provider Phone: _____Provider Fax: _____

Birth/Placement of a child

Name of Child: _____

You must include documentation supporting the date of the child's birth, adoption, or placement:

- Newborn: DOB____/____/____
- Foster Child Placement, Date of Placement: ____/____/____
- Date of Adoption: ____/____/____

To be completed by Human Resources: Date Form Received: _____ Letter Mailed _____