**FMLA Medical Certification Form**

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**Employee Information**

* Name: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Job Title: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Department: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Contact Number: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Medical Condition**

* Description of the condition requiring leave: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Date condition commenced: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Estimated duration of condition: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Care Requirements**

* Does the patient require inpatient care?  
  + Yes
  + No
* Does the patient require continuing treatment by a healthcare provider?  
  + Yes
  + No

**Treatment Schedule**

* Frequency of treatment: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Duration of treatment: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Dates of scheduled treatment, if applicable: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Health Care Provider Information**

* Name: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Address: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Phone Number: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
* Type of Practice/Specialization: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Certification**

* I certify that the information provided is accurate to the best of my knowledge and that the employee requires FMLA leave for the reasons stated above.
  + Signature of Health Care Provider: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
  + Date: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Employee Signature**

* I understand that the information provided will be used for the purpose of validating my FMLA leave.
  + Signature of Employee: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]
  + Date: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]