FMLA Medical Certification Form

FMLA Medical Certification Form

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: [_____]

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- 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: [_____]

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