Family/Medical Leave
Healthcare Provider Certification Form

NOTE: The information sought on this form pertains only to the condition for which the employee is requesting leave under FMLA.

To be completed by the Employee

Employee Name:	**Employee #:**
Patient Name (if not employee)	Relation to Employee: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____________
State the nature of the care you will provide if Family Leave is requested to care for a family member with a serious health condition:	
State/estimate the time period for which such care will be provided. Include a schedule if requesting leave on an intermittent or reduced schedule.	
Employee Signature	**Date**

To be completed by the Healthcare Provider

Physician/Practitioner Name:	**Specialization/Type of Practice:**
Address:	**Phone:**

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment or prescription medication): ____

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____ **If Pregnancy > projected date of delivery:** _______________

Illness – Date condition commenced:	**Probable duration of condition:**	**Estimated return to work date:**

Was the patient admitted for an overnight stay in a hospital, hospice or residential care facility? ☐ Yes ☐ No

If **YES,** please list **DATES OF ADMISSION**:

FOR INTERMITTENT LEAVE ONLY: Will it be medically necessary for the employee to work on an **intermittent/reduced** schedule due to the condition (including for treatment or episodic flare-ups)? ☐ Yes ☐ No
If answer is "yes", please provide:

1. Probable # of treatments: ______________________
2. Interval between treatments: ______________________
3. Dates of treatments if known: ______________________
4. Period of recovery (if any): ______________________
5. Probable duration of need: ______________________
6. Frequency: ______ times per _____ week _____ month
7. Duration: _______ hours or ______ day(s) per episode

FOR CONTINUOUS LEAVE DUE TO PERSONAL OR FAMILY ILLNESS:

A. Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No If so, estimate the beginning and ending dates for the period of incapacity: ___________________ - ____________________

B. If answer to Question A is **YES**, identify the job functions the employee is unable to perform: ____________________

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C. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

D. Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

E. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? ☐ Yes ☐ No If so, state the nature of such treatments and expected duration of treatment:

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F. If leave is required to care for a **family member** with a serious health condition, does the patient require assistance for basic medical or personal needs, safety, or transportation? ☐ Yes ☐ No **DATES**: ________________________

G. If "D" above is "No", would the employee's presence provide psychological comfort and be beneficial to the **family member** or assist in recovery? ☐ Yes ☐ No **DATES**:______________________

____ ______________
HEALTHCARE PROVIDER SIGNATURE (Do not use stamp or designee signature) **Date**

COMPLETE AND RETURN ORIGINAL FORM TO: HARFORD COUNTY PUBLIC SCHOOLS - BENEFITS OFFICE
102 S. Hickory Avenue, Bel Air, MD 21014
Phone: 410-588-5275 ✧ Fax: 410-588-5316