

HEALTH CARE PROVIDER STATEMENT
(Family and Medical Leave)

Employee Name	Social Security Number

Patient Name (if other than employee)	Relationship to Employee/Age

1. Date Treatment Began: _____

2. Estimated Date of Release to Work: _____

3. Date of Next Evaluation: _____

4. Please state any limitations on this employee's ability to perform the essential functions of their job, and for what time period.

5. Please indicate if this patient is infected with any contagious disease(s) or has any other injury or illness which could pose a threat to students, other employees, or this employee: **Yes** **No**

6. Does the patient's condition qualify under any of the categories described below (check box):

<input type="checkbox"/> Chronic Condition Requiring treatment*	<input type="checkbox"/> Multiple Treatments (Non-Chronic Conditions)*	<input type="checkbox"/> Permanent/Long-term condition requiring Supervision*
<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Absence Plus Treatment*	<input type="checkbox"/> Hospital Care

(If checked, please explain **severity, duration, intermittent, and episodes an employee may be absent in #8 below).*

7. Will further treatment or therapy be required? **YES** **NO** (If YES, please explain in #8 below)

8. Describe the medical facts, **absent a diagnosis**, which support certification of a serious health condition:

9. If the patient is other than the employee, is the employee needed to care for the patient? **YES** **NO** If YES, approximately how long? _____

10. Comments:

I certify that this information is true and correct to the best of my knowledge and that the patient, as named above, has been and/or is currently under my care. **(Attach additional sheets if needed)**

Signature of Health Care Provider

Title

Address

Telephone Number

Date