MEDICAL CERTIFICATION STATEMENT
(ILLNESS OF EMPLOYEE'S FAMILY MEMBER)

Name of Employee: ___________________________________
Name of family member:_________________________________
Relationship of above individual to employee: _______________________________
Date condition began: _____________________
Estimate of probable duration of the condition: ____________________________________________

Diagnosis of the serious health condition: ________________________________________________________________

Statement of the regimen of treatment prescribed for the condition (including estimated number of visits, nature, frequency, and duration of treatment):

Explanation of the extent to which employee is needed to care for the ill spouse, child, or parent:

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?

Yes
No

Would the employee's presence be beneficial or desirable for the care of the family member?

Yes
No

Date:__________ Signature of Healthcare Provider:_____________________________________

Type of Medical Practice:_____________________________________________

Specialization, if any:_____________________________________________

Office Telephone Number:______________________________________________________

MEDICAL RELEASE

I authorize the release of any medical information, necessary to process my leave request, by my physician or other healthcare provider to the __________ school district.

Date:____________________ Patient's Signature:__________________________________________