HEALTHCARE PROVIDER CERTIFICATION
(INTERMITTENT OR REDUCED LEAVE SCHEDULE)

Name of Employee: _____

Name of family member (if leave is to care for family member): _____

Date condition began: _____

Diagnosis of the serious health condition: _____

I hereby certify that the intermittent leave or reduced leave requested by the employee is medically necessary for the following reasons:

The expected duration of the requested leave is:

The schedule for the leave is:

Is the leave necessary to care for a child, parent, or spouse who has a serious health condition or will it assist the family member's recovery?

Yes
No

Please underline and initial the applicable section if the answer to the above is yes.

Date:_____ Signature of Healthcare Provider:_____

Type of Medical Practice:_____

Specialization, if any:_____

Office Telephone Number:_____