



FOR HUMAN RESOURCES USE ONLY:
Employee Classification (circle one): A M P

MEDICAL CERTIFICATION

A complete medical certification is required to determine whether your health condition, or the health condition of your Spouse, Son, Daughter or Parent, qualifies for leave under FMLA regulations.

Instructions to Employee: Complete Sections I and II. If you are requesting leave to care for your Spouse, Son, Daughter or Parent who has a serious health condition also complete Section III. Your health care provider or your family member's health care provider must complete Sections IV through VII. It is your responsibility to ensure that the health care provider completes this form and is returned to the appropriate address or fax number provided below within 15 calendar days.

Instructions to Health Care Provider: Your patient or a family member of your patient has requested a Family and Medical Leave. In order for us to verify that this qualifies under the FMLA, please complete Sections IV through VII of this form.

For completion by the Employee

Section I – Patient Information (Print)
Employee's Name: _____
Patient's Name (if other than employee) : _____
Relationship to Employee (if son or daughter, provide date of birth): _____
Section II – Employee Signature
I authorize the North East Independent School District Office of Human Resources or its designated health care provider/third party administrator to contact my health care provider or my family member's health care provider for purposes of obtaining clarifying information and authenticity of the medical certification, if necessary.
_____ Employee Signature
_____ Date
Section III – Care for Family Member (Print)
State the care you will provide for your family member (if designated above).



MEDICAL CERTIFICATION
For completion by the Health Care Provider

Section IV – Patient Information (Print)
1. Employee’s Name:
2. Patient’s Name:
3. Patient’s relationship to employee (check one): Self Spouse Son or Daughter Parent

Section V – Designation of Serious Health Condition
Section VI – Duration of Incapacity and Treatments
4. Under FMLA a “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves one or more of the categories below. Does the patient’s condition for which he/she is requesting FLMA leave qualify under any of the categories described? If so, check the applicable category(ies):
5. Indicate Specific Diagnosis:
6. State the approximate date the condition commenced:
7. Estimate the probable duration of condition:
8. Nature and estimated duration of treatment prescribed:

Section VII – Physician Information
Name of Health Care Provider (please print):
Provider’s Signature:
Date: Type of Practice:
Address:
Telephone Number: Fax Number: