File: GBGF-E

Certification of Physician or Practitioner

(Family and Medical Leave Act of 1993)

1. Employee's name ____

2. Patient's name ____

3. Diagnosis ____

   ____

4. Date condition commenced ______________________________________

5. Probable duration of condition __________________________________

6. Regimen of treatment to be prescribed. Indicate number of visits, general nature and duration of treatment including referral to other providers of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.

   a. By physician or practitioner _____________________________________

      ____

   b. By another provider of health services if referred by physician or practitioner

      ____

If this certification relates to care for the employee's seriously ill family member, skip items 7, 8 and 9 and proceed to items 10 through 14. Otherwise continue below.

Check Yes or No in the boxes below as appropriate.

	Yes	No	
7.	❑	❑	Is in-patient hospitalization of the employee required?
8.	❑	❑	Is employee able to perform work of any kind. If “no,” skip item 9.
9.	❑	❑	Is employee able to perform the functions of employee’s position? Answer after reviewing statement from employer of essential functions of employee’s position or if none provided after discussing with employee.

For certification relating to care for the employee’s seriously ill family member, complete items 10 through 14 below as they apply to the family member and proceed to item 17.

	Yes	No	
10.	❑	❑	Is in-patient hospitalization of the family member (patient) required?
11.	❑	❑	Does or will the patient require assistance for basic medical needs, hygiene, nutritional needs, safety or transportation?
12.	❑	❑	After review of the employee’s signed statement (item 14 below), is the employee’s presence necessary or would it be beneficial for the care of the patient? This may include psychological comfort.

13. Estimate the period of time care is needed or the employee’s presence would be beneficial. ____

14. Signature of physician or practitioner ____________________________

15. Date ______________________

16. Type of practice (field of specialization, if any) _______________________

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Item 17 is to be completed by the employee needing family leave.

17. When family leave is needed to care for a seriously ill family member, the employee must state the care he will provide and an estimate of the time period during which this care will be provided including a schedule if leave is to be taken intermittently or on a reduced leave schedule. ____________________

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Employee signature ____

Date _________________________