Family and Medical Leave
Physician Statement

The information sought on this form relates only to the condition for which the employee is taking FMLA leave.

Medical Certification Statement for the **Employee's Own Serious Illness**

1. **Employee's Name:**____

2. **Date condition began:**____

3. **Probable duration** of the condition or incapacity:______________________________

4. **Medical facts** regarding the condition (see attached definition of serious illness): ________

   ____

   ____

   ____

   ____

5. **Explanation of extent to which employee is unable to perform the functions of his or her job:**____

   ____

   ____

   ____

   ____

*I certify that the **"serious health condition"** described above qualifies as an eligible FMLA condition as described in the attached definition:*

Health Care Provider Signature:____

Date:___________________________ Office Phone:______________________________

Type of Practice (Field of Specialization, if any):______________________________

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Medical Release:

I authorize the release of any medical information necessary to process the above request. I understand that this medical information will be treated as confidential and will not be placed in my personnel file.

Signature of employee or authorized representative:______________________________

Date:______________________________