



Haverhill

Human Resources Department, Room 306
Denise McClanahan, HR Director- dmcclanahan@cityofhaverhill.com
Christine Caminero, HR Technician- ccaminero@cityofhaverhill.com
HR: (978) 374-2357 - Benefits: (978) 374-2311 - Fax: (978) 374-2343

FMLA Medical Certification for EMPLOYEE

This section to be completed by the EMPLOYEE:

Name of Employee (Print): _____
Job Title: _____ Leave Period: _____
Department: _____
Reason for Leave: _____

By signing below, you authorize the health care provider to release the following medical information for the purpose of determining compliance with the *Family and Medical Leave Act*.

Employee's Signature: _____ Date: _____

An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.

This section to be completed by the HEALTH CARE PROVIDER:

NOTE: A list of **essential functions of the position** can be sent for your consideration.
If needed, please contact us at (978) 374-2357.

Certification of Health Care Provider (Family and Medical Leave Act of 1993)

Patient's Name: _____

(Signature of Health Care Provider)

(Type of Practice)

Printed name of Health Care Provider

(Address)

(Phone number)

(Date)

The following information relates only to the condition for which the employee is taking FMLA covered leave:

Completed form must be returned to Room 306 at City Hall



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This page to be completed by the HEALTH CARE PROVIDER for the health condition of the EMPLOYEE

Please complete or check ALL on this page that apply:

ALL questions must be answered and all information completed for FMLA approval to be granted.

Start date of condition: _____

Serious Health Condition Type Category 1__ 2__ 3__ 4__ 5__ 6__
(See **attached** FMLA Definition of Serious Health Conditions for criteria.)

As FMLA certification, briefly DESCRIBE the medical facts and state how the medical facts meet the criteria of an FMLA qualifying serious health condition:

Probable treatments estimate (if applicable):

If a regimen of continuing treatment of the patient is required under your supervision, provide a general description of such regimen and treatment schedule: (e.g., prescription drugs, physical therapy requiring special equipment)

Statements given below of "unknown" will be returned for clarification. PLEASE give time estimates.

Is the employee currently able to perform work of any kind?

☐ Yes ☐ No (If no, the employee will not be permitted to work until a **medical release statement** is provided by the health care provider.)

If no: for how long will the employee be off work? _____

If yes: Are there any **restrictions** regarding performance of the essential functions of the position and what is the **duration** of restrictions? (see **attached** list of the essential job functions)

How long will an intermittent or part time schedule likely be necessary? _____

How often will the employee likely be absent from work (e.g., estimated # of days per wk/mo/yr)?

Signature of Health Care Provider _____ Date: _____