Haverhill

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

FMLA Medical Certification for FAMILY MEMBER

This section to be completed by the EMPLOYEE:

Name of Employee (Print): _____
Job Title: _____ Leave Period: _____
Department: _____
Reason for Leave: _____
Family Member's name and relation: _____

I hereby 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:

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
FAMILY MEMBER 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:

_____

_____

Is the patient/family member in need of the employee to provide basic medical or personal needs or safety, or for transportation for a serious health condition?
☐ Yes ☐ No

Would the employee's presence to provide psychological comfort be beneficial to the patient/family member or assist in the patient's recovery from serious health condition?
☐ Yes ☐ No

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

Does the employee currently need to be absent from work full time for this need? ☐ Yes ☐ No

If yes: for how long of a time period? _____

If no: and the patient will need care only intermittently or on a part-time basis, please indicate below (i.e., How often and for what periods of time will the employee likely to be absent from work for the care or comfort of the patient/family member?:
How long with the intermittent or part-time schedule likely be necessary? _____

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

_____

Signature of Health Care Provider_____ Date: _____