Certification of Health Care Provider for
Family Member's Serious Health Condition
under the Family and Medical Leave Act

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR .
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires:

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (Check all that apply)

Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your best estimate of the amount of leave needed to provide the care described: _____

_____

(5) If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced schedule you are able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy), I am able to work _____ (hours per day) by _____ days per week.

Employee Signature _____ Date _____ (mm/dd/yyyy)

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. A family member of your patient has requested hsa-1 (e)Snm/4.6 (w2-2.8 h)8J Eh1.4 (-Ffa).4 MyLeTa(w2-2.8e(o)97 (r)-14 (day)1-1 (yy)2-26.1 (u1-2 (r).3 (ts2-

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