

MEDICAL CERTIFICATION STATEMENT

Name of Employee: _____
(Last) (First) (Middle)

To The Physician:

The above-named employee is requesting extended medical leave under the Family and Medical Leave Act (FMLA). He/She is requested to provide medical certification supporting the need for leave due to either (1) a serious health condition affecting the employee, **or** (2) a serious health condition affecting the employee's immediate family member (spouse, child, or parent).

Individual suffering the serious health condition: _____
(Name)

Relationship of patient if other than the employee: _____

Estimated time employee will be away from his/her workplace:

Beginning Date: _____

Return to Work Date: _____

Statement of Certification: As primary attending physician to the above-named individual suffering the serious health condition, I do hereby certify the need for _____ (Employee's Name) to take leave as stipulated by the above conditions.

Signature of Physician Date

Physician's Typed or Printed Name

Address

City/State/Zip

MEDICAL RELEASE

I authorize the release of any medical information, necessary to process my leave request, by my physician or other healthcare provider to the Southwest Technology Center school district.

Date

Patient's Signature