

**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