Medical Certification by Health Care Professional – Family Member

Complete this form if leave is due to the employee caring for a family member

Section 1 – To be completed by Employee

Employee Name:	Employee ID Number:

What type situation applies to your case?

- ❑ Birth of child
- ❑ The adoption of a child by the employee, or the placement of a child with the employee for foster care (Legal certification, not medical, will be required in this case)
- ❑ Care for family member with serious health condition

Relationship of Family Member to Employee:

- ❑ Spouse
- ❑ Parent
- ❑ Child (Child's age: _____)
- ❑ Other:

(Note: For FMLA related leave – Federal law indicates that leave can only be used in caring for a spouse, parent, or child)

What is the nature of the care you will be providing?

What type of time off do you anticipate needing*?

❒ A block of time from _____ to _____
Starting Date Ending Date

❒ Intermittent or reduced schedule. Please indicate the probable duration of this need and attach a schedule if you are caring for a family member:

I certify the information listed above is true and complete. I understand that I can contact Human Resources if I have any questions.

_____ _____
Employee Name Date

Section II – To be completed by Health Care Provider – Certification of Medical Condition of a Seriously Ill Family Member.

A. **Check the category that matches the patient's condition.** ***See attached sheet, which describes what is meant by a "serious health condition".***

☐ 1. Hospital Care	☐2. Outpatient Surgery	☐ 3. Absence plus Treatment	☐ 4. Chronic Conditions Requiring Treatments
☐ 5. Pregnancy	☐ 6. Permanent/Long-term Conditions Requiring Supervision	☐ 7. Multiple Treatments (Non-Chronic Conditions)	☐ 8. None of the above

B. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
❒ Yes ❒ No

If no, would the employee's presence provide psychological comfort to the patient or assist in the patient's recovery?
❒ Yes ❒ No

C. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

D. State the approximate **date** condition commenced and the probable duration of condition:

Name of Healthcare Provider (Print)	Type of Practice (Specializations, if any)	Telephone Number ( ) -

_____ _____
Health Care Provider Signature Date

Imperial Valley College Human Resources: (760)355-6212 Fax: (760)355-6211

* Employees have 12-weeks in a 12-month period in which they *may* qualify for FMLA. **Any previous time off under FMLA in the past 12 months will be deducted from the current 12-week period.**