



**Medical Certification Statement
(Employee's Own Serious Illness)
TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

All questions must be answered and all information completed for FMLA approval to be granted. Statements given below of "unknown" or "undetermined" will be returned for clarification. Please give time estimates.

• Name of Employee: _____

• Date condition started: _____

If more than 6 months ago, please indicate onset of **present** incapacity: _____

• Date condition ended: _____
(or is expected to end): _____ 30 days _____ 60 days _____ 90 days
_____ more than 90 days (please specify) _____

• Medical facts which support your certification statement: _____

• Is the employee currently able to perform work of any kind? _____ Yes _____ No

If **yes**, list any restrictions to the employee's performance of his/her job functions:

If **no**, the employee will not be permitted to work until a medical release statement is provided by the health care provider.

PLEASE COMPLETE ONLY THE SECTION THAT RELATES TO THE EMPLOYEE'S MEDICAL CONDITION:

A. Incapacity recurring only on an intermittent basis or requiring a reduced schedule.

• If it is necessary for the employee to work intermittently or to work on less than a full schedule due to this condition:

How **long** will an intermittent or part-time schedule likely be necessary (please estimate)?

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

B. Acute incapacity (employee is unable to work for entire duration, but the incapacity should be resolved within 90 days).

How **long** will the employee likely be absent from work (please estimate)? _____

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

C. Chronic incapacity which is ongoing and extends over a period of time (more than 90 days).

How **long** will the employee likely be absent from work (please estimate)? _____

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

HEALTH CARE PROVIDER INFORMATION:

(Printed Name of Health Care Provider)

(Specialty)

(Signature of Health Care Provider)

Date: _____ Office Phone: _____

I authorize the above health care provider to release any additional health information requested by Creighton and related to this medical certification. This authorization expires six (6) months from the date signed by me.

I understand that:

- I have the right to revoke this authorization at any time, provided that I submit my written revocation to above provider's office.
- Any revocation of this authorization does not apply to disclosures already made by my health care provider in reliance on this authorization or for disclosures otherwise required by law.
- Health information obtained from other health care professionals, which is in my health record, may be released pursuant to this request unless I specifically advise my health care provider not to release such information.
- I have the right to review my health record before signing this authorization. The provider's Notice of Privacy Practice explains how to request access to my health record.

Patient signature

Date