



**Medical Certification Statement
(Illness of Employee's Family Member)
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: _____
- Name of Family Member Needing Care: _____
- 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: _____

- Does the employee **currently** need to be absent from work **full-time** for this need? ___ Yes ___ No

If **yes**, for how long of a time period (please estimate)? _____

If **no**, and the family member will need care only **intermittently or on a part-time basis**, please indicate below:

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)?

- Is the family member needing care a child **18 years or older**? ___ Yes ___ No

If **yes**, explain the extent to which the child is incapable of self care because of a mental or physical disability (e.g., such as caring for one's grooming and hygiene, dressing, eating, cooking, cleaning, etc.)

HEALTH CARE PROVIDER INFORMATION:

(Signature of Health Care Provider)

(Printed Name of Health Care Provider)

(Specialty)

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