



**MEDICAL CERTIFICATION FOR
EMPLOYEE'S FAMILY SERIOUS HEALTH CONDITION**
Please return completed forms to Absence Management
14201 School Lane, Room 132 Upper Marlboro, MD 20772
Phone: 301-952-6200 Fax: 301-760-3593 Email: absence.mgmt@pgcps.org

SECTION I: TO BE COMPLETED BY THE EMPLOYEE:

To qualify for FMLA entitlements, you must submit a complete, sufficient, and timely medical certification to support a request for FMLA leave to care for a family member's serious health condition. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a sufficient and complete medical certification will result in a denial of your FMLA request. You will have 15 calendar days to return this form to Absence Management.

Employee's Name: _____ **EIN:** _____
First Middle Last

Work Organization: _____ **Job Title:** _____

Name of family member for whom you will provide care: _____
First Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care: _____

***** Please note: Your leave usage will be determined by your union negotiated contract. There are rules regarding the use of your sick leave to Care for a Family Member (refer to your contract for more information). *****

*By signing below, I authorize all treating provider(s) to release information obtained in the evaluation and treatment to Absence Management. Further, I grant Absence Management permission to verify all supporting documents to determine eligibility and FMLA entitlements.
I must submit a Request for Extension Form or your intent to return to work letter to Absence Management 10 days prior to an approved leave ending. An employee cannot return to work without a medical release.*

Employee's Signature: _____ **Cell Phone #:** _____ **Date:** _____

****Due to HIPAA LAW: This form should be kept confidential and provided to Absence Management ONLY upon completion****



Medical Certification for Employee's Family Serious Health Condition

SECTION II: TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

The employee has requested leave under the FMLA to care a family member with a serious medical condition. Where indicated, your documentation should provide specific dates. Terms, such as, "lifetime," "unknown," or "unable to determine," cannot be used to establish eligibility for an Extended Leave Request. If the medical decision requires documentation of undetermined frequency and uncertain duration of a condition, use your best estimation of time and frequency.

PART A: REQUIRED DOCUMENTATION OF SERIOUS HEALTH CONDITION BY THE HEALTH CARE PROVIDER:

Table with 4 columns: Diagnosis, IC, Prognosis, Patients' required care needs

PART B: MEDICAL FACTS TO DETERMINE AMOUNT OF LEAVE NEEDED BY CAREGIVER (PGCPS EMPLOYEE)

All requests are required to have an estimated ending date in order to determine eligibility

1.) The caretaker will need to provide medical care to the patient on a continuous basis.

BEGINNING DATE: ___/___/___ ENDING DATE: ___/___/___
Month Day Year Month Day Year

OR

2.) The caretaker will need intermittent periods and still continue to work while providing medical care to the patient. # of days per month: ___

BEGINNING DATE: ___/___/___ ENDING DATE: ___/___/___
Month Day Year Month Day Year

SPACE FOR ADDITIONAL DOCUMENTATION

Blank lines for additional documentation

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.
Health Care Provider's Name: _____ Provider's ID# _____ (Required)
Type of Specialty: _____ Telephone: _____
Business Address: _____
Signature of Health Care Provider: _____ Date: _____
(Stamp signatures are not acceptable)