

**Family/Medical Leave
Certification of Leave for
Employee's Own Condition**



THE OFFICE OF HUMAN RESOURCES

Dear Employee: Please complete the "Certification of Employee" section of this form before asking the healthcare provider to complete the provider's section of the form.

Dear Provider: The below-named employee is seeking leave pursuant to the federal Family and Medical Leave Act (FMLA), which requires you to complete the healthcare provider section of this form. Thank you for your cooperation.

CERTIFICATION OF EMPLOYEE

1. Employee's Name:
2. Employee's Social Security Number
3. Manager's Name:
4. Human Resources Contact:
5. State the health condition/s that make/s you unable to perform the essential functions of your job:

6. State the estimated dates and times you will need leave:

I hereby certify that the above information is true and correct. I understand that Lewis University or its agents may have the right and/or obligation to seek clarification of or to verify the accuracy of information contained on this form, including by contacting the healthcare provider who completes this form. I understand that I may be subject to disciplinary action if a certification form containing factual misrepresentations is submitted to Lewis University.

Employee's Signature _____ Date _____

CERTIFICATION OF HEALTH CARE PROVIDER

1. Describe the medical facts that support your certification and the reason the employee needs the leave:

CONDITION

- | | | | | |
|--|------|------|----|----|
| 2. Is the employee's condition pregnancy? | Yes | No | | |
| 3. Did/will the condition* require in-patient care? | | Yes | No | |
| If "Yes": | | | | |
| a. What were/are the estimated dates of hospitalization? | | From | | To |
| b. Where was/is the hospitalization | | | | |
| 4. What is the expected duration of the condition? | From | | To | |

* Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking a FMLA leave.

TREATMENT

5. Has/will the condition require/d treatment** by of under the supervision of a healthcare provider? Yes No
If yes, please provide a general description of the frequency and nature of those treatments:

6. Will the treatments require that the employee lose time from work? Yes No

If yes:

- a. State the nature of treatments (e.g., office visit, therapy, referral, etc.):
- b. During what period do you anticipate such treatments will be needed?
From To
- c. What is the frequency of such treatments?
- d. How much time is needed for each treatment, including recovery time, if any?
- e. What are the dates and times available for such treatment?

WORK LIMITATIONS

7. Is the employee unable to perform work *of any kind* because of his/her condition? Yes No

8. a. If the employee is able to perform some work, list the functions of the employee’s job the employee is *unable* to perform (e.g., heavy lifting, excessive standing or sitting, repetitive motions, etc.)

b. State the date or dates (past, present and anticipated) of such inability.

**Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations.

I hereby certify to the best of my medical knowledge, the above information is true and correct and that it is based on my personal examination of the patient.

Signature of Healthcare Provider

Date

Printed Name of Healthcare Provider

Type of Practice

Street Address

City

State

Zip

Telephone Number

FAX Number

PLEASE RETURN COMPLETED FORM BY FAX AND MAIL ORIGINAL TO:

Office of Human Resources
Lewis University
One University Parkway
Romeoville, Illinois 60446

Fax: 815 / 836-5900
Phone: 815 / 836-5270