Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

Carnegie Mellon University
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SECTION I: For Completion by the EMPLOYER

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This section is not required and can be left blank.

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ___Yes. If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
___No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy ___No ___Yes.

_____

_____

_____

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_____

_____

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_____

Signature of Health Care Provider Date