FMLA Medical Certification Form

Employee Information

- **Employee Name: ________________________________**
- **Employee ID: __________________________________**
- **Department: __________________________________**
- **Supervisor: ___________________________________**

Patient Information (if different from employee)

- **Patient Name: _________________________________**
- **Relationship to Employee: _______________________**
- **Date of Birth: _________________________________**

Medical Condition

- **Serious Health Condition Description: _____________**
- **Date Condition Commenced: _____________________**
- **Probable Duration: ______________________________**

Treatment Details

- **Treatments Required: ____________________________**
- **Frequency of Treatments: _________________________**
- **Duration of Treatments: __________________________**

Certification

- **Health Care Provider Name: ______________________**
- **Provider Address: _______________________________**
- **Provider Phone Number: ___________________________**

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- **Provider Email: ___________________________________**

Certification and Signature

- **Health Care Provider Signature: _____________________**
- **Date: ____**

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