HEALTHCARE PROVIDER CERTIFICATION
(INTERMITTENT OR REDUCED LEAVE SCHEDULE)

Name of Employee: _____

Name of family member (if leave is to care for family member): _____

Date condition began: _____

Diagnosis of the serious health condition: _____
_____
_____
_____

I hereby certify that the intermittent leave or reduced leave requested by the employee is medically necessary for the following reasons: _____
_____
_____
_____

The expected duration of the requested leave is: _____

The schedule for the leave is: _____

Is the leave necessary to care for a child, parent, or spouse who has a serious health condition or will it assist the family member's recovery?

_____ Yes
_____ No

Please underline and initial the applicable section if the answer to the above is yes.

_____
Date

_____
Signature of Healthcare Provider

_____
Type of Medical Practice

_____
Specialization, if any

_____
Office Telephone Number