

ATTACHMENT XV
MEDICAL RECERTIFICATION FROM HEALTH CARE PROVIDER
FMLA LEAVE
(to be submitted within 15 days of Board requesting it)

Employee's Name: _____ Position: _____

Building: _____

Reason for Employee requesting FMLA leave (circle one):

1. To care for an immediate family member (son, daughter, spouse, or parent) with a serious health condition; or
2. The Employee's own serious health condition prevents him/her from performing the functions of his/her job (i.e. the health care provider determines that the Employee is unable to work at all or is unable to perform any of the essential functions of the Employee's position within the meaning of the Americans with Disabilities Act).

If reason #1 has been circled above, indicate the name and relationship of the immediate family member (patient):

Name of Treating Health Care Provider: _____

Medical Practice (Field of Specialization, if any): _____

Date FMLA leave commenced: _____

Date of most recent medical certification: _____

Changes in probable duration of the condition: _____

Changes from the most recent medical certification (including changes in the health care provider's diagnosis and regimen of treatment prescribed):

Health Care Provider's Signature

Date

Address

Telephone Number

Employee's Signature

Date

THIS IS A CONFIDENTIAL RECORD AND IT SHALL BE MAINTAINED AS SUCH
AS REQUIRED BY THE AMERICANS WITH DISABILITIES ACT.