MEDICAL CERTIFICATION REQUIREMENTS

Instructions to the employee:

In order to certify your eligibility for FMLA Medical, each section will identify the documents and information you need to provide. Read carefully. You will be asked at the bottom of this form to sign that you have read and understand the certification requirements.

SET A: ***Documents you need based on the reason you are requesting the leave.*** **Provide the documents listed for the reason you selected.**	
☐ **To care for your child, foster child, parent or spouse**	**Certification from the health care provider who is treating my child, parent or spouse including all of the following:** • The date on which the condition commenced • The probable duration of the condition • The appropriate medical facts within the knowledge of the health care provider regarding the condition • An estimate of the time needed to care for the individual involved (including any recurring medical treatment) • A statement that the condition warrants my participation to provide care
☐ **For your personal care**	**Certification from the health care provider who is treating my own serious health condition, including all of the following:** • The date on which my condition commenced • The probable duration of my condition • The appropriate medical facts within the knowledge of the health care provider regarding my condition • A statement that I am unable to perform the functions of my position due to my condition.
☐ **For adoption or foster Placement**	• A statement from the court or state official documenting the adoption or placement in foster care. • An estimate of the expected duration and schedule of time off.

SET B: ***Documents you need based on the leave schedule you are requesting.*** **Select schedule 1, or schedule 2; then provide the documents listed for the schedule you selected.**	
☐ **Full-time FMLA Leave**	No additional documents are needed.
☐ **Intermittent leave (one that requires that you periodically or occasionally be away from work) or reduced work schedule…**	**…to care for your child, foster child, parent or spouse.** 1. A statement attesting to the necessity of intermittent leave or reduced work schedule for me to provide care or to assist their recovery. 2. An estimate of the expected duration and schedule of my intermittent or reduced work schedule.
	…to care for yourself. 1. A statement of medical necessity for my intermittent leave or reduced work schedule and the expected duration of the schedule. 2. A listing of the dates of my planned medical treatment and the duration of the treatment(s).

I certify by my signature that I have read and understand the City's FMLA medical certification policy.

Name: _____ **Date:** _____
(Print)

Signature: _____ **Employee Number:**_____