Glenbard Township High School District 87

CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(Family and Medical Leave Act of 1993)
Employee Illness

1. Employee/Patient Name:_____

This Section to be Completed by Physician: INSTRUCTIONS to the HEALTH CARE PROVIDER:
Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

2. Diagnosis:_____

_____

3. Date condition commenced: _____

4. Probable duration of condition:_____

5. Regimen of treatment to be prescribed.
   a. By Physician or Practitioner:_____

   _____

   _____

   b. By another provider of health services, if referred by Physician or Practitioner:_____

   _____

   _____

Print Physician Name:_____

Signature of Physician or Practitioner: _____

Date:_____Office Phone No. _____

Office Address:_____

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

RETURN COMPLETED CERTIFICATION TO:
Human Resource Coordinator
596 Crescent Blvd.
Glen Ellyn, IL 60137
phone: 630–469–9100 • fax: 630–469–9107

Revised: 4/2015