Glenbard Township High School District 87

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

1. Employee's Name:_____

2. Patient's Name:_____

3. Relationship to Employee: _____

This Section to be Completed by Physician:
4. Diagnosis:_____

_____

5. Date condition commenced: _____6. Probable duration of condition:_____

YES NO
8. ____ ____ Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
9. ____ ____ Will the employee's presence be necessary/beneficial for the care of the patient?

10. Estimate the period of time needed or the employee's presence would be beneficial.
Date care to start_____ Date care to end _____

Print Physician Name:_____

Signature of Physician or Practitioner: _____

Date:_____Office Phone No. _____

Office Address:_____

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

NOTE: TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

When Family Leave is needed to care for a seriously ill family member, the employee will state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if the leave is to be taken intermittently or on a reduced-leave schedule:_____

_____

_____

Employee Signature:_____Date:_____

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