

CERTIFICATION OF HEALTH CARE PROVIDER

Health Care Provider's Name _____ (Area Code) Telephone Number _____

Health Care Provider's Group Name _____ Address _____

EMPLOYEE'S PERSONAL INJURY/ILLNESS

Employee's Name _____

Date Illness/Injury Commenced: _____ Probable Duration or Ending Date: _____

Describe the serious health condition which makes the employee unable to perform the essential functions of his/her position. Attach additional page(s) if necessary.

CARE OF FAMILY MEMBER

Name of Family Member _____

Relationship to Employee _____

Date(s) employee's presence is necessary for care of family member:

Beginning Date: _____ Ending Date: _____

Describe the serious health condition of family member. Attach additional page(s) if necessary.

Date

Signature of Health Care Provider (No Stamps, please)