EAST GEORGIA COLLEGE

CERTIFICATION OF PHYSICIAN OR PRACTITIONER
*** FAMILY AND MEDICAL LEAVE ***

1. **Employee's Name:** ____

2. **Patient's Name (If other than employee):**______________________________

   Relationship to Employee: ______________________________________

3. **Diagnosis:** ____

   ____

4. **Date condition commenced:** ____________________________________

5. **Probable duration of condition:** _________________________________

6. **Regimen of treatment to be prescribed** (Indicate number of visits, general nature and duration of treatment, including referral to other providers of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)

   a. **By physician or practitioner:**________________________________

   ____

   ____

   b. **By another provider of health services, if referred by physician or practitioner:** ____________

   ____

IF THIS CERTIFICATION RELATES TO THE CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 7, 8, AND 9 AND PROCEED TO ITEMS 10 THRU 14. OTHERWISE, CONTINUE BELOW.

	YES	NO	
7.	____	____	Is in-patient hospitalization of the employee required?
8.	____	____	Is employee able to perform work of any kind? (If "NO", skip Item 9)
9.	____	____	Is employee able to perform the functions of his/her position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEMS 10 THRU 14 AS THEY APPLY TO THE FAMILY MEMBER.

	YES	NO	
10.	____	____	Is inpatient hospitalization of family member (patient) required?
11.	____	____	Does (or will) the patient require assistance for basic medical care, hygiene, nutritional needs, safety or transportation?
12.	____	____	After review of the employee's signed statement (see item 14 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psycho-logical comfort.)

13. **Estimate the period of time care is needed or the employee's presence would be beneficial**:

____

Item 14 is to be completed by the employee when requesting Family Leave to care for a seriously ill family member. The employee shall state:

14.a. The care he or she will provide: ____

____

b. An estimate of the time period during which this care will be provided (including a schedule if leave is to be taken intermittently or on a reduced leave schedule): ____________________________

____

____ ____________________

Employee's Signature **Date**

I attest that the above-named employee of East Georgia College should be allowed to use Family and Medical Leave. This is based on the medical necessity of this situation and is substantiated by the information contained in this Certification.

____ ____________________

15. **Physician or Practitioner's Signature** **Date**

16. **Type of Practice (Field of Specialization, if any):** ______________________________________

17. **Address of Physician or Practitioner:** ____

____

18. **Phone Number**: (_______) ______________________________

RETURN FORM TO: East Georgia College, Human Resources, 131 College Circle, Swainsboro, GA 30401