Certification of Health Care Provider for Employee's Family Member's Serious Health Condition

Please have this form completed and returned within 15 calendar days to: ***Clay Community School Central Office***
1013 S. Forest Ave., Brazil, IN 47834

Employee name: _____
(First Name) (Middle Initial) (Last Name)

Name of family member for whom you will provide care:	
Relationship of family member to you:	□ Spouse □ Child □ Parent
If family member is your son or daughter:	date of birth ____/____/____

Employer name and contact: *Clay Community Schools, 1013 S Forest Ave. Brazil, IN 47834, Attn: HUMAN RESOURCE DEPT.*

Employee's job title: _____ **Regular work schedule:** _____

Employee's essential job functions: _____

_____

For completion by the HEALTH CARE PROVIDER

Provider's name and business address: _____

_____

Type of Practice / Medical Specialty:

_____

Telephone: (____) _____ **Fax:** (____) _____

Approximate date condition commenced ____/____/20___	Illness ____ Accident ____ Other____ explain:	
Probable duration of leave for this condition	Days_____ Week(s) _____ Other:(explain)	
Was patient admitted overnight in a medical care facility?	Yes ___ No ___	If so, date(s) admitted:
Was the patient referred to another health care provider(s) *(e.g. physical therapist, surgeon, specialist, etc.)*	Yes ___ No ___	If so, where- Treatment- Date(s)-
Will follow-up appointments be likely?	Yes ___ No ___	If so, approx. how many and approx. duration:
Please describe other relevant medical facts, if any, related to the condition for which employee seeks leave: *(e.g. therapy, surgery, rehabilitation, etc.)*		

_____ _____

Signature of Health Care Provider **Date**