

**Medical Certification Statement
(Illness of Employee's Family Member)**

Name of Employee: _____

Name of Ill Family Member: _____

Date Condition Began: _____

Date Condition Ended (or is expected to end): _____

Medical facts regarding the condition: _____

Explanation of extent to which employee is needed to care for the ill spouse, child or parent:

Health Care Provider Signature: _____

Date: _____ Office Phone: _____

Medical Release:

I authorize the release of any medical information necessary to process the above request.

Patient's Signature: _____ Date: _____