Family FMLA Certification

(Employee and Physician/Health Care Professional Certification
of care required for employee's seriously ill family member.)

Employee Information

Name: ____ SSN: ______________________

USC Department: ____

Patient's Name: ___________________________________ Relationship: __________________

Patient is a member of the Armed Forces or is on the Armed Forces Temporary Disability Retired List: Yes No

Describe care to be given family member:

Estimate the period of time during which this care will be provided: _______________ to: _______________

Describe your schedule if leave is to be intermittent or you propose to work on a reduced schedule:

Employee Signature: ____________________________________ Date: __________________

Physician/Health Care Professional Certification

Is inpatient hospitalization of the family member (patient) required? Yes No

Does or will the patient require assistance with basic medical, hygiene, nutritional needs, safety or transportation? Yes No

Please review the employee's signed statement. Is the employee's presence necessary or would it be beneficial for the care of the patient? Yes No

Period of time care is needed or the employee's presence would be beneficial: ____________ to ______________

Physician/Health Care Professional Name: _________________________ Date: __________________

Type of practice/specialization: ______________________________ Office Phone: ____________

Physician/Health Care Professional Signature: ____