

**CERTIFICATION OF PHYSICIAN OR PRACTITIONER**  
**(Family and Medical Leave Act of 1993)**

**TO BE COMPLETED BY EMPLOYEE**

Employee's name \_\_\_\_\_

Patient's Name \_\_\_\_\_

Patient's Relationship to Employee \_\_\_\_\_



**FOR FAMILY LEAVE**

Describe care to be given to family member \_\_\_\_\_

Estimate the period of time during which this care will be provided: From: \_\_\_\_\_

To: \_\_\_\_\_

Describe schedule if leave is to be taken intermittently or on a reduced schedule: \_\_\_\_\_

I hereby authorize the release of any related medical information requested by the College of Charleston, Human Resources Department.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

DIAGNOSIS: \_\_\_\_\_  
\_\_\_\_\_

Date condition commenced \_\_\_\_\_ Probable duration of condition (dates) \_\_\_\_\_

TREATMENT: Please describe the regiment of treatment to be prescribed indicating the estimated number of visits, nature, frequency and duration of treatment, including treatment by another health care provider by referral. (Attach additional documentation if necessary.)  
\_\_\_\_\_

**IF PATIENT IS EMPLOYEE**

Yes  No Is inpatient hospitalization of the employee required?

If yes, give dates: \_\_\_\_\_

Yes  No Is employee able to perform work of any kind?

If yes, please describe \_\_\_\_\_

Yes  No Is employee able to perform the functions of employee's position? If No, please describe

\_\_\_\_\_  
\_\_\_\_\_

When will the employee be able to return to work?  
\_\_\_\_\_

**IF PATIENT IS A SERIOUSLY ILL FAMILY MEMBER**

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

Yes  No Does (or will) the patient require assistance for 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?

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

From: \_\_\_\_\_ To: \_\_\_\_\_

I certify that the information contained on this form is both accurate and factual.

Physician or Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_

Type of Practice (Field of Specialization, if any) \_\_\_\_\_

**PLEASE RETURN THIS FORM TO: College of Charleston, Human Resources, 66 George Street, Charleston, SC 29424**  
**Or FAX (843) 953-5986 Office phone: (843) 953-5512**