

Employee's Certification of Own Serious Health Condition
Family and Medical Leave Act of 1993 (FMLA)

Employee Name (Print): _____

1. Description of serious health condition: To qualify for your own serious illness under the FMLA, your condition must qualify as a “serious health condition” under the definition in the law. Does your condition qualify under any of the categories described? (See Definition of “Serious Health Condition” form.) If so, please check the applicable category.

1__ 2__ 3__ 4__ 5__ 6__

2. Duration of the condition:

a. Date the condition began: _____

b. Probable duration of the condition: _____

Employee Signature and Date: _____