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: _______________________________________