

**Family Member's Serious Health Condition**  
Family and Medical Leave Act of 1993 (FMLA)

Employee's name (Print): \_\_\_\_\_

1. Patient's name: \_\_\_\_\_

Relationship to employee:    Child \_\_\_\_\_    Spouse \_\_\_\_\_    Parent \_\_\_\_\_

2. Description of serious health condition (see Definition of "Serious Health Condition" form):  
Does the patient's condition qualify under any of the categories described? If so, please check  
the applicable category:

1\_\_ 2\_\_ 3\_\_ 4\_\_ 5\_\_ 6\_\_

3. Medical facts: Please describe briefly the medical facts that fit the category checked above,  
without including a specific diagnosis or prognosis:

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

4. Duration of condition and incapacity:

a. Date the condition began: \_\_\_\_\_

Probable duration of the condition: \_\_\_\_\_

Probable duration of the patient's present incapacity (if different): \_\_\_\_\_

b. If the condition is pregnancy (condition #3) or a chronic condition (condition #4),  
state whether the patient is presently incapacitated and what the likely duration and  
frequency of episodes of incapacity might be.

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

5. If additional treatments will be required for the condition, please describe the nature of such  
additional treatment under your supervision (e.g., prescription drugs, physical therapy  
requiring special equipment), the probable number of such treatments, and the actual or  
estimated dates of the treatment, if known.

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

6. Need for employee's care:

- a. Does the patient require assistance for basic medical, hygiene, nutritional needs or for transportation?    Yes\_\_\_ No\_\_\_
- b. If no, would the employee's presence provide beneficial psychological comfort that would assist in the patient's recovery?    Yes\_\_\_ No\_\_\_
- c. Will it be necessary for the employee to take time off, work intermittently, or work on a less than full schedule, as a result of the patient's condition and /or treatments?  
Yes\_\_\_ No\_\_\_

If yes, give the probable duration: \_\_\_\_\_

Healthcare Provider Signature and Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_