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: ___________________________________________________________________