UNIVERSITY OF WEST FLORIDA
FAMILY LEAVE FORM (USDOL)
CERTIFICATION OF PHYSICIAN OR HEALTH CARE PROVIDER
(FAMILY AND MEDICAL LEAVE ACT OF 1993)

1. Employee's Name	2. Patient's Name (if other than employee)
3. Diagnosis	
4. Date condition commenced	5. Probable duration of condition
6. Is inpatient hospitalization of the family member (patient) required? ( ) Yes ( ) No	
7. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ( ) Yes ( ) No	
8.After review of the employee's signed statement (See item 10 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) ( ) Yes ( ) No	
9. Estimate the period of time care is needed or the employee's presence would be beneficial.	
10. When Family Leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.	
11. Employee Signature	12. Date
13. Signature of Physician or Practitioner	14. Date
15. Type of Practice (Field of Specialization, if any.)	