Physician Certification for Family or Medical Leave

Municipality of Monroeville
2700 Monroeville Blvd.
Monroeville, PA 15146

PLEASE PRINT

Name_____ Title_____

Department_____ Employee Payroll No._____

Status: ☐ Full Time ☐ Part Time ☐ Temporary Date____/____/_____

To be completed by Human Resources

The above named Employee is requesting family and medical leave from work with his/her employer_____

It is our understanding that you are currently treating_____

The Patient is: ☐ the Employee ☐ Spouse of the Employee ☐ Parent of the Employee ☐ Child of the Employee

☐ The Employee is requesting full leave from_____/_____/_____ until_____/_____/_____

☐ The Employee is requesting leave on an intermittent or reduced schedule for the following dates:_____

_____

_____

☐ Job description (if Applicable) is attached.

Please assist us by clarifying the facts about the patient by filling out the information below.

1. As a duly authorized medcial care provider, I verify that I am currently treating_____
2. The Patient has been diagnosed and is receiving treatment for the following condition:_____

_____

_____

3. The relevant medical facts regarding the Patient's condition include the following:_____

_____

_____

_____

4. The condition began on: _____/_____/_____
5. In my opinion, that condition will last until (provide date if possible)_____
6. As a result of that codition, it is my opinion that:

☐ The Employee is currently unable to perform his/her employment functions set forth on the attached job description.
☐ The Employee is currently needed to care for the Patient.
☐ Intermittent leave is medically necessary for the Employee, or to care for the Patient.
☐ None of the above.

7. In my opinion, the Employee will not be able to return to work until (provide date if possible)_____

_____

8. If the Patient requires treatment of medical condition that necessitates intermittent leave, please describe the treatments to be administered:_____

_____

_____

9. The dates of these treatments will be_____

_____

_____

_____

10. In my opinion, the treatments will last until_____

_____

11. As a result of the Patient's condition and/or necessary treatment, it is my opinion that the Employee will be unable to perform his or her employment functions, or is needed to care for the Patient, and therefore unable to work during the following intermittent periods:

From___/___/___	Until___/___/___	From___/___/___	Until___/___/___
From___/___/___	Until___/___/___	From___/___/___	Until___/___/___
From___/___/___	Until___/___/___	From___/___/___	Until___/___/___

_____ ___/___/___

Physician's Signature Date

_____

Physician's printed name

Office mailing address_____

_____

_____ Phone (___)_____

Physician's Comments:_____

_____

_____

_____

_____