Haverhill

Human Resources Department, Room 306
Denise McClanahan, HR Director – dmcclanahan@cityofhaverhill.com
Sheila Pelczar, HR Technician – spelczar@cityofhaverhill.com
Christina Carrie, Head Clerk – ccarrie@cityofhaverhill.com
HR: (978) 374-2357 - Benefits: (978) 374-2311 - Fax: (978) 374-2343

FMLA Medical Certification for EMPLOYEE

This section to be completed by the EMPLOYEE:

Name of Employee (Print): ____________________
Job Title: ____________________ Leave Period: ____________________
Department: ____________________
Reason for Leave: ____________________

By signing below, you authorize the health care provider to release the following medical information for the purpose of determining compliance with the *Family and Medical Leave Act.*

Employee's Signature: ____________________ Date: ____________________

An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.

This section to be completed by the HEALTH CARE PROVIDER:

NOTE: A list of **essential functions of the position** can be sent for your consideration.
If needed, please contact us at (978) 374-2357.

Certification of Health Care Provider (Family and Medical Leave Act of 1993)

Patient's Name: ____________________

____
(Signature of Health Care Provider) **(Type of Practice)**

____
Printed name of Health Care Provider

____
(Address) **(Phone number)** **(Date)**

The following information relates only to the condition for which the employee is taking FMLA covered leave:

____

____

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Completed form must be returned to Room 306 at City Hall

4 Summer Street Haverhill, MA 01830 www.haverhillma.gov

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This page to be completed by the HEALTH CARE PROVIDER for the health condition of the EMPLOYEE

Please complete or check ALL on this page that apply:

ALL questions must be answered and all information completed for FMLA approval to be granted.

Start date of condition: ________________________

Serious Health Condition *Type* Category 1__ 2__ 3__ 4__ 5__ 6__
(**See attached** *FMLA Definition of Serious Health Conditions* for criteria.)

As FMLA certification, briefly DESCRIBE the medical facts and state how the medical facts meet the criteria of an FMLA qualifying serious health condition:

____

____

Probable treatments estimate (**if** applicable):
If a regimen of continuing treatment of the patient is required under your supervision, provide a general description of such regimen and treatment schedule: (e.g., prescription drugs, physical therapy requiring special equipment)

____

____

Statements given below of "unknown" will be returned for clarification. PLEASE give *time estimates*.

Is the employee currently able to perform work of any kind?
☐ Yes ☐ No (If no, the employee will not be permitted to work until a **medical release statement** is provided by the health care provider.)

If no: for how long will the employee be off work? ________________________________

If yes: Are there any **restrictions** regarding performance of the essential functions of the position and what is the **duration** of restrictions? (see attached list of the essential job functions)

____

How long will an intermittent or part time schedule likely be necessary? ________________________

How often will the employee likely be absent from work (e.g., estimated # of days per wk/mo/yr)?

____

Signature of Health Care Provider____Date: ______________

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