ESSEX COUNTY COLLEGE
HUMAN RESOURCES DEPARTMENT
FAMILY AND MEDICAL LEAVE (FML) REQUEST

CERTIFICATION OF PHYSICIAN
(Family and Medical Leave Act of 1993)

1. Employee's Name: _____

2. Patient's Name (If other than employee): _____ Relation to Employee: _____

3. Diagnosis: _____ Probable duration of condition: _____

4. Date condition commenced: _____

5. Estimate the period of time care is needed or the employee's presence would be beneficial: _____

6. Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. **Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week).** You may attach additional documentation, if needed:

_____
_____
_____
_____

[ ] CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE Please circle.

	[Yes]	[No]	
7.	Yes	No	Is inpatient hospitalization of the employee required?
8.	Yes	No	Is employee able to perform work of any kind?
9.	Yes	No	Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

[ ] CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER

10.	Yes	No	Is inpatient hospitalization of the family member (patient) required?
11.	Yes	No	Does (or will) the patient require assistance for basic medical, hygiene, nutritional need, safety or transportation?
12.	Yes	No	After review of the employee's signed statement (See Item 13 below), is the employee's presence necessary or would it be beneficial for the care of the patient?

[ ] TO BE COMPLETED BY THE EMPLOYEE

13. 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 which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule. Attach your statement to this document.

I certify that information provided for this FML Request is true and correct.

_____ _____ _____
Signature of Physician (Field of Specialization) Date:

_____ _____
Employee Signature Date:

FML Request must be submitted:
Essex County College
Human Resources Director
Room 5112
(973) 877-3084

(1/98)