



## Certification of Health Care Provider

Employee's Name:	Employee ID #:
Work Unit:	

### ***Employee's Personal Health Condition***

Projected Absence:	Begin Date:	End Date:
Describe the health condition, which makes the employee unable to perform the essential functions of his/her position. (Attach additional pages if necessary.)		

### ***Health Condition of Family Member***

Family Member:		Relationship:	
Date(s) employee is needed for the care of family member:	Begin Date:	End Date:	
Describe the health condition of the family member, which requires the employee's presence. Attach additional pages if necessary.			

Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(no stamps please)