MEDICAL CERTIFICATION STATEMENT
(ILLNESS OF EMPLOYEE'S FAMILY MEMBER)

Name of Employee: ____
Name of family member: ____
Relationship of above individual to employee: ____
Date condition began: ____
Estimate of probable duration of the condition: ____
____
Diagnosis of the serious health condition: ____
____
____

Statement of the regimen of treatment prescribed for the condition (including estimated number of visits, nature, frequency, and duration of treatment): ____
____
____

Explanation of the extent to which employee is needed to care for the ill spouse, child, or parent: ____________
____
____

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?

_______ Yes
_______ No

Would the employee's presence be beneficial or desirable for the care of the family member?

_______ Yes
_______ No

______________________________ Date

______________________________ Signature of Healthcare Provider

______________________________ Type of Medical Practice

______________________________ Specialization, if any

______________________________ Office Telephone Number

MEDICAL RELEASE

I authorize the release of any medical information, necessary to process my leave request, by my physician or other healthcare provider to the Caney Valley school district.

______________________________ Date

______________________________ Patient's Signature