

**NATIONAL RADIO ASTRONOMY OBSERVATORY
Associated Universities, Inc.**

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

GENERAL INFORMATION

EMPLOYEE NAME: _____

PATIENT NAME (IF DIFFERENT): _____

DIAGNOSIS: _____

DATE CONDITION STARTED: _____

PROBABLE DURATION: _____

COMPLETE THIS SECTION FOR EMPLOYEE REQUIRING MEDICAL CARE

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Is inpatient hospitalization of the employee required? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the employee able to perform work of any kind? If no, skip next question. |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the employee able to perform the functions of the employee's position? |

If it is medically necessary for the employee to work on an intermittent basis or to work a lesser number of hours please provide details below:

COMPLETE THIS SECTION FOR DEPENDENT REQUIRING MEDICAL CARE

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Does the family member require inpatient hospitalization? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does (or will) the family member require assistance for basic medical, hygiene, nutritional needs, safety or transportation? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the employee's presence necessary or would it be beneficial for the care of the family member? |

Estimate the period of time the employee's presence would be beneficial: _____

Physician's Signature

Date