The J. Paul Getty Trust
Human Resources

Medical Certification: FML/CFRA/Non-FML*

A. Employee Section

Employee Name:	Program/Department:	Employee ID#:	Date:

Patient's Name:

Patient's Relationship to Employee:

Requested Leave Start Date:	Anticipated Return to Work Date:

Employee Signature ____________________ Date ____________

B. Physician or Health Care Provider Section

Date Condition Began:	First Day of Disability:	Estimated Return to Work Date:

If intermittent or reduced schedule leave is medically necessary, please explain:

Complete for <u>Employee</u> Illness:

Is inpatient hospitalization required?	☐ Yes	☐ No
Is employee able to perform work of any kind? (if no, skip next question)	☐ Yes	☐ No
Is employee able to perform essential functions of employee's position? (Review employer's essential function statement)	☐ Yes	☐ No

Treatment Regimen/Comments:

Complete for <u>Family Member</u> Illness:

Is inpatient hospitalization required?	☐ Yes	☐ No
Does patient require employee's assistance for basic medical, hygiene, nutritional needs, safety or transportation?	☐ Yes	☐ No
Is the employee's presence necessary or would it be beneficial for the care of the patient?	☐ Yes	☐ No

Estimate the period of time employee's care or presence is needed for family member:

C. Physician or Health Care Provider Information

Physician Signature ____________________ Date ____________

Print Name of Physician:

Practice Specialty:	Phone Number:

☐ Original to Human Resources

*** Form Required for all Medical Leaves**

May 2012