Please return form to Hope King-Randall in Human Resources
Phone: 843-488-6559 Fax: 843-488-7754 Email: hrandall@horrycountyschools.net

CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

Employee Name: ______________________________________ **Employee ID:** ______________________
Family Member Name: ________________________________

For Completion by the HEALTH CARE PROVIDER INSTRUCTIONS to the HEALTH CARE PROVIDER:
The employee listed above has requested leave under the FMLA to care for your patient.

Provider's name: ____

Telephone: (________) ______________________________ **Fax :**(_________)_______________________________

AMOUNT OF CARE NEEDED:
When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.
2. Estimate the beginning and ending dates for the period of the patient's incapacity:
   Begin: ____________________ End: ___________________
3. During this time, will the patient need care? __ No __ Yes.
   Explain the care needed by the patient and why such care is medically necessary:
   ____
   ____
   ____
   ____
   ____

____ ____
Signature of Health Care Provider **Date**

____ ____
Health Care Provider Name (Please Print) **Office Phone Number**