



Please return form to **Natasha Montgomery** in Human Resources

Phone: 843-488-6559

Fax: 843-488-7754

Email: [nmontgomery@horrycountyschools.net](mailto:nmontgomery@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