



**MEDICAL CERTIFICATION STATEMENT**  
(Illness of Employee's Family Member)

Employee Name: \_\_\_\_\_

Ill Family Member Name: \_\_\_\_\_

Date Condition Began: \_\_\_\_\_

Date (Expected) End: \_\_\_\_\_

Relevant Medical Facts:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature (Health Care Provider)

\_\_\_\_\_  
Date

Medical Release:

I authorize the release of any medical information necessary to process the above request:

\_\_\_\_\_  
Signature (Patient)

\_\_\_\_\_  
Date