

**GEORGETOWN UNIVERSITY MEDICAL CERTIFICATION FORM  
FOR FAMILY/MEDICAL LEAVE**

**I. EMPLOYEE INFORMATION**

Employee's Name: \_\_\_\_\_ GU ID: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Patient's Name, if other than Employee: \_\_\_\_\_

**II. DIAGNOSIS AND TREATMENT**

Diagnosis: \_\_\_\_\_

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

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

Probable Duration of Treatment: \_\_\_\_\_

Regimen of prescribed treatment (indicate # visits, general nature and duration of treatment, including referral to other health care provider; include schedule of visits/treatment if medically necessary for employee to be off work on an intermittent basis or to work less than his/her normal schedule of hours per day/week)

By Physician/Practitioner: \_\_\_\_\_

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

By another health care provider, if referred by physician/practitioner:

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

**III. EMPLOYEE'S ILLNESS**

Complete only if leave relates to employee's own illness.

Is inpatient hospitalization of employee required? [ ] Yes [ ] No

Is employee able to perform work of any kind? [ ] Yes [ ] No

If yes to previous question, is employee able to perform the functions of his/her position? (Answer after reviewing employer's job description or after discussing with employee.) [ ] Yes [ ] No

**IV. CARE OF FAMILY MEMBER -- Complete only if leave relates to care of family member.**

Is inpatient hospitalization of the family member (patient) required? [ ] Yes [ ] No

Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? [ ] Yes [ ] No

After review of employee's signed statement, below, is employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) [ ] Yes [ ] No

Estimate the period of time care is needed or the employee's presence would be beneficial:

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

Employee's statement regarding Family/Medical Care for seriously ill family member. State the care you will provide and an estimate of the time period during which this care will be provided, include a schedule if leave is to be taken intermittently or on a reduced work schedule:

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

**V. PHYSICIAN/PRACTITIONER SIGNATURE:**

Date: \_\_\_\_\_

Type of Practice/Specialization \_\_\_\_\_

Address: \_\_\_\_\_