



An employee who requests family and medical leave due to a serious health condition may be required to provide medical certification. An employee is not required to obtain medical certification for the first six calendar weeks of leave following childbirth.

MEDICAL CERTIFICATION FORMS ARE MAINTAINED IN FILES SEPARATE FROM GENERAL EMPLOYEE PERSONNEL RECORDS AND ARE TREATED AS CONFIDENTIAL MEDICAL RECORDS IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT AND THE FAMILY AND MEDICAL LEAVE ACT OF 1993.

**SECTION 1: TO BE COMPLETED BY THE EMPLOYEE**

Employee Name: [Click here to enter text.](#) Employee ID Number: [Click here to enter text.](#)  
Division: [Choose an item.](#) Position Title: [Click here to enter text.](#)

Briefly explain the reason for leave  
[Click here to enter text.](#)

I hereby authorize (physician's name) \_\_\_\_\_ to provide information to The Helena College University of Montana regarding my/my dependent's (if the employee is requesting leave to care for a seriously ill child, spouse, or parent) medical condition, disability, illness, or injury and my ability to work.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**SECTION 2: TO BE COMPLETED BY THE PHYSICIAN**

1. Explain the medical condition, disability, illness, or injury for which the patient is being treated:

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

2. Prescribed treatment (for example: number of visits, general nature and duration of treatment, including referral to other provider of health services):

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

3. Is inpatient hospitalization required? \_\_\_\_\_ Yes \_\_\_\_\_ No

IF THIS CERTIFICATION IS RELATED TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, PLEASE SKIP ITEMS 4 THROUGH 9 AND PROCEED TO ITEM 10.

4. Is the employee able to perform the functions of his/her position? (The employer may provide and request your review of a description of the employee's position. Otherwise, such information may be obtained through a discussion with the employee).  
\_\_\_\_\_ Yes \_\_\_\_\_ No

5. Will the employee's work activities need to be limited upon return to work?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, list a tentative date employee may resume work on a limited or restricted basis and recommended duration of limited work assignment:

\_\_\_\_\_

6. List duties or activities the employee is able to perform: \_\_\_\_\_

\_\_\_\_\_

7. List any other restrictions (such as hours of work): \_\_\_\_\_

8. Will any activities or duties be limited permanently? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

9. What is the tentative date the employee may resume with no limitations? \_\_\_\_\_

**PLEASE COMPLETE ITEMS 10 THROUGH 15 FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER.**

10. Patient's name: \_\_\_\_\_

11. Is inpatient hospitalization required? \_\_\_\_\_ Yes \_\_\_\_\_ No

12. Does (or will) the patient require assistance for basic medical hygiene, nutritional needs, safety or transportation? \_\_\_\_\_ Yes \_\_\_\_\_ No

13. Is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include providing psychological comfort or providing other basic needs such as hygiene, nutrition, safety or transportation.) \_\_\_\_\_ Yes \_\_\_\_\_ No

14. Estimate the period of time that care is needed or during which the employee's presence will be beneficial:

\_\_\_\_\_

15. Prescribed treatment (for example: number of visits, general nature and duration of treatment, including referral to other provider of health services):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have any additional comments, please attach them and check here: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Business Phone Number

Please return this form to: **Helena College University of Montana  
Human Resources  
1115 North Roberts Street  
Helena, MT 59601**