



State University of New York College at Fredonia

Employee Leave Certification

Employee Name _____ Department _____

Title _____ Date of Injury/Illness _____

This individual is employed by the SUNY College at Fredonia and as such they are engaged in rendering essential public services which have direct effect on the health and welfare of faculty and staff. Their presence at work is required and necessary.

You are asked to certify if they are physically or mentally incapacitated from work of any kind. The following information is required before the employee can receive leave credit.

Diagnosis _____

Medication and/or Treatment Prescribed _____

Beginning Date of Incapacity _____ Follow-Up Visit? (circle) Y / N

Ending Date of Incapacity _____ Date Follow-Up Scheduled _____

Is this employee incapacitated to an extent which precludes them from doing work of any kind? (circle one) YES / NO

If NO, please elaborate: _____

Physician's Name (please print) _____
Physician's Address _____ Phone _____
Physician's Signature _____ Date _____

I hereby allow my physician to release the above information to my employer.

Employee Signature _____ Date _____

(Use reverse to request a Leave of Absence because of a serious illness to a spouse, child or parent).

**Certification of Physician or Practitioner
Relating to Care of Employee's Seriously-Ill Family Member**

Employee's Name _____

Patient's Name _____ Relationship _____

Diagnosis _____

Date condition commenced _____ Probable duration of condition _____

Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week in order to care for the seriously ill family member).

By Physician or Practitioner _____

By another provider of health services, if referred by Physician or Practitioner _____

(Circle one)

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

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

When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.

Physician's name (print) _____	Phone _____
Specialty _____	
Signature of Physician or Practitioner _____	Date _____

Employee Signature _____ Date _____