Illness/Medical Leave Verification Form

Office of Human Resources
Mail Station #10
4200 S. Congress Avenue
Lake Worth, FL 33461
Fax (561)868-3131

Employee: Please complete this section before giving this form to the medical provider.

Your name: _____

If requesting FMLA for a family member's serious health condition:

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

Employee Signature _____ Date _____

Health Care Provider: Your patient has requested medical leave. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign and use your official stamp.

DIAGNOSIS: _____

_____

_____

_____

Is the medical condition pregnancy? ____No ___Yes. If so, expected delivery date: _____

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ____No ____Yes If so, estimate the beginning and ending dates for the period of incapacity: _____

Will the employee need a reduced schedule because of the employee's medical condition? ____No ___Yes.

Reduced work schedule, if any: _____ hour(s) per day; _____ days per week
from _____ through _____
(date) (date)

Special Instructions/Restrictions (please estimate length):

_____

_____

_____

_____

No Restrictions as of: _____

Return to work date: _____

_____

Provider's name and business address

_____ _____

Signature of Health Care Provider **Phone number** **Fax number**

OFFICIAL STAMP: