Clarksville Montgomery County School System
Health Care Provider Certification
(Family Member)

To be completed by Employee:

Employee Name:_____ Employee ID#_____

Job Title: _____ Work Location:_____

Name of family member to whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Employee Signature Date

To be completed by Health Care Provider:

Providers name and business address:_____

Type of practice/medical specialty: _____

Telephone: _____ Fax: _____

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

Medical Condition of family member:

_____
_____
_____
_____

Estimated timeframe, **employee's** care and assistance is needed to support family member:

_____
_____
_____
_____

Additional Information you would like to provide to the employer regarding this medical condition:_____
_____
_____
_____
_____
_____

_____ _____
Signature of Health Care Provider Date