UNCW
HUMAN RESOURCES

Medical Certification FMLA
(Employee's Own Illness)

Name of Employee: _____

Describe medical condition: _____

_____

Date Condition Began or due date for maternity: _____

Date ended (or expected to end): _____

Explanation of extent to which employee is unable to perform the essential functions of his or her job:
Please refer to attached job description.

_____

_____

Physician's Signature: _____ Date: _____

Physician's Name (print): _____ Phone: _____

Address of Physician: _____

_____

_____

Phone Number: _____

Fax Number: _____

I give my physician permission to release medical information necessary to complete the above certification.
I am requesting the following time off work:

Employee's Signature: _____