



University of North Carolina Wilmington

**Medical Certification FMLA
(Family Member Illness)**

Name of Employee: _____

Name of Patient: _____

Relationship of Patient to Employee: _____

Describe medical condition: _____

Is inpatient hospitalization required? _____ Yes _____ No

Does Family member require assistance for basic medical, hygiene, nutritional needs, safety or transportation? _____ Yes _____ No

Is the employee's presence necessary or would it be beneficial for the care of the patient? _____ Yes _____ No
(This may include psychological comfort.)

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

From: _____ To: _____
Or

Approximate period of time: _____(e.g.:wks, mos)

Physician's Signature: _____ Date: _____

Printed Name of Physician: _____

Address of Physician: _____

Phone Number: _____

Fax Number: _____