



Personal Assistance Options, Inc.

Midland Towne Center; 1509 Washington Street Suite B; Midland MI 48640

Ph: 989-837-8350; FAX: 989-698-0101

Web site: www.PAOmidland.org

REQUEST FOR FAMILY AND MEDICAL LEAVE OF ABSENCE

I, _____, request a leave of absence from employment under the Family and Medical Leave Act. I have been employed by my employer for at least twelve months total and have worked at least 1,250 hours for my employer during the past twelve months. I request this leave of absence because:

_____ I am unable to perform the essential functions of my position because of a severe health condition. I understand that I will be required to provide a medical statement which certifies that the health condition exists and that I am unable to perform the essential functions of my position. I also understand that at the conclusion of the leave, I will be required to provide certification that I can perform the essential functions of my position.

_____ Certification attached

_____ Certification to be provided _____ (date)

_____ I need to care for (indicate child, spouse or parent) who has a serious health condition. I understand that I will be required to provide a medical statement which certifies that the health condition of this relative exists and estimates the length of time that I should need in order to provide care for this relative.

_____ Certification attached

_____ Certification to be provided _____ (date)

_____ I will be providing care for a newborn child of mine.

_____ I will be providing care for an adopted or foster child being placed with me.

(Check one of the above)

Employee's Signature

Date

Approved By

Date

PAO Mission: *Providing support to individuals with disabilities based on their personal needs and goals*



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**CERTIFICATION OF HEALTH CARE PROVIDER
(Family and Medical Leave Act of 1993)**

1. Employee's name: _____
2. Patient's name (if different from employee): _____
3. The attached sheet describes what is meant by a serious health condition under the Family and Medical Leave Act. Does the patient's condition¹ qualify under any of the categories described? If so, please check the applicable category.

(1) (2) (3) (4) (5) (6) or None of the above
4. Describe the medical facts that support your certification, including a brief statement on how the medical facts meet the criteria of one of these categories:
5. a. State the approximate date the condition commenced and its probable duration (and also the probable duration of the patient's present incapacity,² if different):

b. Will it be necessary for the employee to work only intermittently or on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)?

If yes, give the probable duration:

- c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated² and the likely duration and frequency of episodes of incapacity.²

¹Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

²Incapacity, for purposes of the FMLA, is defined to mean inability to work, attend schools or perform other regular daily activities due to the serious health condition, treatment for it, or recovery from it.



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6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:
If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:
- b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:
- c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):
7. a. If a medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? _____
- b. If able to perform some work, is the employee unable to perform at least one of the essential functions of the employee's job (the employer or the employee should supply you with information about the essential job functions)? _____. If yes, please list the essential functions the employee is unable to perform:
- c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? _____

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8. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? _____
- b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _____
- c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

(Signature of Health Care Provider)

(Type of Practice)

(Address)

(Telephone Number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

(Employee signature)

(Date)