

**The University of Southern Mississippi  
The Department of Human Resources**

**Family/Medical Leave Certification Form**

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**Section I**

(To be completed by Employee)

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Family Member's Name if other than Employee: \_\_\_\_\_

Relationship to Employee: \_\_\_\_\_

I hereby make application for a Leave of Absence, starting on \_\_\_\_/\_\_\_\_/\_\_\_\_ (month,day,year), and will return to work on \_\_\_\_/\_\_\_\_/\_\_\_\_. With my signature, I authorize, the below Doctor/Health Care Provider to release information concerning my or my family members medical records to The University of Southern Mississippi. Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Section II**

(To be complete by Doctor or Health Care Provider)

Is the employee able to perform the essential functions of his/her position?

Yes  No  Other, explain: \_\_\_\_\_

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Is the employee needed to care for a family member?

Yes  No  Other, explain: \_\_\_\_\_

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Is intermittent leave or a reduced work schedule medically necessary?

Yes  No  Other, explain: \_\_\_\_\_

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Date illness began: \_\_\_\_/\_\_\_\_/\_\_\_\_ Estimated date of recovery: \_\_\_\_/\_\_\_\_/\_\_\_\_

Estimated date to return to work: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please describe the treatment/prognosis required for the employee or family member:

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Signature of Doctor/Heath Care Provider: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Print) Name and Address: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_