



MEDICAL CERTIFICATION FOR LEAVE OF ABSENCE

Instructions for the Medical Provider: Please complete the sections below to certify the medical necessity for a leave of absence under FMLA/CFRA guidelines. The district does not require a specific diagnosis narrative, but explicit parameters regarding timelines and work restrictions must be verified.

SECTION I: EMPLOYEE INFORMATION

Employee Full Name:	_____	Date of Birth:	_____
School Site / Dept:	_____	Job Title:	_____
Contact Email:	_____	Phone Number:	_____

SECTION II: MEDICAL PROVIDER DETAILS

Physician Name:	_____	Medical License #:	_____
Practice Specialty:	_____	Phone Number:	_____
Facility Address:	_____		

SECTION III: CLINICAL LEAVE TIMELINE & SPECIFICATIONS

Please select the appropriate leave accommodation category based on medical assessment:

- | | |
|--|--|
| ☐ Continuous Full-Time Leave: | The employee is completely incapacitated for work from _____ through _____. |
| ☐ Intermittent Leave Schedule: | The medical condition causes episodic flare-ups preventing the employee from performing tasks.
Estimated Frequency: _____ times per week/month. Duration per episode: _____ hours/days. |
| ☐ Reduced Work Schedule: | The employee can work a modified schedule from _____ through _____.
Maximum allowable work hours: _____ hours per day; _____ days per week. |
| ☐ Pregnancy Disability Leave (PDL): | The leave is explicitly required due to pregnancy, childbirth, or related medical complications.
Anticipated Delivery Date: _____. Expected recovery end date: _____. |

SECTION IV: HEALTHCARE PROVIDER SIGNATURE

I hereby certify that the medical information listed above is true, accurate, and falls strictly within my official scope of medical practice.

Authorized Medical Provider Signature

Date Signed

This is for informational purposes only. For medical advice or diagnosis, consult a professional. AI responses may include mistakes.