CITY OF BRYAN
The Good Life, Texas Style.

CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION
(Family and Medical Leave Act)

PART B: AMOUNT OF CARE NEEDED

Keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

1. Explain the care needed and why such care is medically necessary: _____

   _____

   _____

2. Will the patient be incapacitated and require care for a single continuous period of time due to their medical condition?
   ☐ No ☐ Yes If yes, beginning and ending dates: _____

3. Will the patient require care on a part-time or reduced schedule basis, or to attend follow-up treatments?

   ☐ No ☐ Yes If yes, please estimate:

   _____ Hour(s) per day; _____ Day(s) per week From (date) _____ through (date) _____

4. Will the patient have episodic flare-ups preventing him/her from participating in normal daily activities and require care during this time?

   ☐ No ☐ Yes If yes, estimate the frequency and duration over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ number of episodes every _____ ☐ week(s) or ☐ month(s)

   Duration: _____ hour(s) or _____ day(s) per episode

   From (date) _____ through (date) _____

ADDITIONAL INFORMATION

_____

_____

_____

Provider's Name and Business Address: _____

Type of Practice / Medical Specialty: _____

Telephone: _____ **Fax**: _____

_____ **Date**: _____

Signature of Health Care Provider