Habersham County Schools – HR Department
PO BOX 70
Clarkesville, GA 30523
Phone: 706-754-2110 x133 Fax: 706-754-3185 Email: dtrotman@habershamschools.com

FAMILY MEDICAL LEAVE CERTIFICATION FORMS

Employee/Patient Name:_____

BIRTH OF A CHILD

Expected delivery date: _____
Your doctor must sign the **Health Care Provider Information at the bottom of this form.
****Employee must have physician complete a Fitness-For-Duty Report form or a signed release when cleared to return to work without restrictions.**

EMPLOYEE ILLNESS/DISBILITY

Date Disability Commenced:_____ Probable Duration or Ending Date:_____
Doctor's statement or description of appropriate medical facts regarding the patient's health condition for which FMLA leave is requested: (Attach additional pages if necessary) _____
_____
_____
Your Doctor must sign the **Health Care Provider Information at the bottom of this form.
*** Employee must have physician complete a Fitness-For-Duty Report form or a signed release when cleared to return to work without restrictions.**

CARE OF A FAMILY MEMBER

Name of Family Member:_____ Relationship:_____
Dates needed for care of Family Member: Beginning Date:_____ Ending Date:_____
Doctor's statement or description of appropriate medical facts regarding the patient's health condition for which FMLA leave is requested: (Attach additional pages if necessary)_____
_____
_____
The Doctor must sign the **Health Care Provider Information at the bottom of this form.

ADOPTION / FOSTER CARE PLACEMENT

** Attach a copy of official documentation of Birth, Adoption, or Foster Care to this Request for Family Medical Leave

MILITARY LEAVE

****Caregiver Leave:** Attach a copy of official medical documentation for injured or ill military family member
****Qualifying Exigency Leave:** Attach a copy of official Active Duty Orders or other military documentation.

HEALTH CARE PROVIDER INFORMATION

Physician's Name:_____ Business Name:_____

Phone Number:_____ License Number:_____

Address: _____

Date:_____ Signature of Health Care Provider:_____