# THE UNIVERSITY OF MISSISSIPPI
## Medical Certification Form

This form is to be used to certify regular Major Medical Leave in excess of 24 hours, Family and Medical Leave (FMLA), Workers' Compensation (WC), or absences due to Donated Leave. A doctor or health care provider must complete and sign Section II.

**To be completed by Employee:**

**SECTION I**

Employee Name: _____ SSN: _____

Family Member's Name Requiring Employee's Absence (if other than employee): _____

Relationship to Employee: _____

Date(s) Leave Requested: _____ to _____

In case of a Family and Medical Leave request, I understand that this form serves as my notification.

_____ _____
Employee's Signature (or Personal Representative) Date

Check all that apply: Regular Major Medical ☐ FMLA ☐ WC ☐ Donated ☐

**To be completed by Doctor or Health Care Provider:**

**SECTION II**
Doctor or Health Care Provider Certification

| | Yes | No | N/A |
|---|---|---|---|
| If employee is ill, is the employee able to perform the essential functions of his/her position? (See the attached job description) | ☐ | ☐ | ☐ |
| Is it necessary that this employee be absent to care for a family member? | ☐ | ☐ | ☐ |
| Is intermittent leave or a reduced work schedule medically necessary? | ☐ | ☐ | ☐ |

Date illness began: _____

Estimated length of illness: _____

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

_____

_____

In your professional opinion, when will the employee be able to return to work? _____

_____ _____
Signature of Doctor/Health Care Provider Date

_____ _____
Printed Name and Address of Above Telephone Number