CITY OF BALTIMORE
FAMILY AND MEDICAL LEAVE
RECERTIFICATION OF HEALTH CARE PROVIDER

----------To Be Completed by Employer----------

1. Employee's Name: _____

2. Patient's Name (if different from employee): _____

3. Date of original certification: _____

4. Dates of FMLA leave taken since original certification: _____

----------To Be Completed by Physician----------

Changes in Condition: Has Patient's condition (check one)

- ☐ Stayed the same
- ☐ Improved
- ☐ Deteriorated

If condition has <u>improved</u>,

Yes	**No**	
☐	☐	Will additional treatments for this condition be necessary?
☐	☐	Is the patient able to care for him or herself?
☐	☐	Is patient, if city employee, able to return to a regular work schedule?

Omit The Following Section if the Patient is not a City Employee

If the condition has <u>deteriorated or stayed the same</u>,

Yes	**No**	
☐	☐	Are there any physical limitations?
☐	☐	Will additional treatments be necessary for this condition?
☐	☐	Is it necessary for employee to work intermittently or work a reduced schedule (hours per day or days per week) in order to receive proper treatment for this health condition?

Physician's Signature: _____ Date: _____
Physician's Printed Name: _____
Physician's Telephone Number: _____

I, _____, give permission for my physician to release the above information to my employer.

_____ _____
Employee Signature Date