

**CERTIFICATION OF HEALTH CARE PROVIDER FOR  
FAMILY MEMBER'S SERIOUS HEALTH CONDITION**

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time for treatment and recovery?  No  Yes

If yes, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_ to \_\_\_\_\_

During this time, will the patient need care?  No  Yes

Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

Will the patient require care on an intermittent or reduced schedule basis,  
including any time for recovery?  No  Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ day(s) per week from \_\_\_\_\_ through \_\_\_\_\_

Explain the care needed by the patient, and why such care is medically necessary:

Will the condition cause episodic flare-ups periodically preventing the patient from participating  
in normal daily activities?  No  Yes