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

Wichita State University *Office of Human Resources* Wichita, Kansas 67260-0015
Phone- (316) 978-3065* Fax- (316) 978-3201

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