Clear Form

MIAMI DADE COUNTY PUBLIC SCHOOLS
ILLNESS OF A FAMILY MEMBER QUESTIONNAIRE

Employee Name: _____ **Employee Number:** _____

Name of Patient: _____ **D.O.B.:** _____ **Relationship to Employee:** _____

- Do they reside with you? ☐ Yes ☐ No (if no, provide address) _____
  Will you commute every day?_____

- Describe the required day's activities you will assist your family member with. Who cares for them at other times?

  _____

  _____

  _____

- Why do you have a need to care for your family member now / what has changed? _____

  _____

  _____

  _____

- Is the family member in hospice or nursing home? ☐ Yes ☐ No

- How often do you see/visit your family member? _____

  _____

- Is the family member a student or working (if so, where (explain)?_____

  _____

- Is anyone else beside you caring for the family member? ☐ Yes ☐ No (If yes, who and explain the care arrangement.) _____

  _____

I certify, under the penalty of perjury and disciplinary action, including, but not limited to termination of employment, that the foregoing information is true and correct.

I also understand that my or my healthcare representative's failure to cooperate in the verification of the foregoing information may result in denial of the FMLA request. I further understand that I may not take leave without approval and that said unapproved leave may constitute abandonment of my employment and may result in disciplinary action, including, but not limited to termination of employment.

_____ _____

Employee Signature Date