MIAMI DADE COUNTY PUBLIC SCHOOLS
MEDICAL CERTIFICATION RELEASE FORM FOR ILLNESS OF A FAMILY MEMBER

In order to determine your eligibility for protected family medical leave under the Family Medical Leave Act (FMLA), applicable Board policy and/or collective bargaining agreement, Miami Dade County Public Schools (M-DCPS) requires specific information from your ill family member's health care provider. Please have them sign the Authorization to Release Information below giving their provider permission to release information to M-DCPS. This certification must be returned to the Leave Office within 15 days of the request for leave.

Employee Complete This Section (Please Print or Type):

Name: ____
(Last) (First) (Middle Initial)

Employee Number: ____

Family Member Information

Patient Name: ____
Name Of Family Member The Employee Is Caring For

Relationship to Miami Dade County School Board Employee: ______________________

AUTHORIZATION TO RELEASE INFORMATION: I authorize the Leave Office and/or healthcare representative for Miami Dade County Public Schools to contact my health care provider for purposes of verification, clarification and/or authentication of medical documentation submitted to Miami Dade County Public Schools. I understand the reason for this medical certification is to determine my family member's eligibility for medical leave under state, federal regulations, applicable School Board policy and/or collective bargaining agreement.

This release will remain in effect until terminated by me in writing to the Leave Office.

Patient Signature: ______________________________ Date: ____________
SIGNATURE OF PATIENT
FAMILY MEMBER SIGNATURE