# FMLA Application Form For Pregnancy

To be completed by you and a licensed health care provider for the purpose of determining the approximate length of leave under the Family Medical Leave Act.

**TO BE COMPLETED BY EMPLOYEE**

I authorize my medical provider(s) _____ to complete this form based on information from my patient file and provide this form to the District 120 Human Resources Director.

First Name: _____ Middle Initial: _____ Last Name: _____

Signature: _____ Date: _____

**Anticipated Dates of Leave**

**From: _____/_____/_____ to _____/_____/_____.**

**Instructions for the Health Care Provider**

Your patient is requesting leave under the Family Medical Leave Act. The Genetic Information Nondiscrimination Act of 2008 prohibits employers from requesting or requiring genetic information of an individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by this law, includes an individual's family medical history, results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

*I certify that I am the medical provider for the person identified above and that this patient is pregnant.*

***Provider's Name:*** _____

***Provider's Business Address:*** _____

***Telephone:*** *(____)* _____ ***Fax:*** *(____)* _____

***Signature of Health Care Provider:*** _____ ***Date:*** _____

**When completed please fax this form to (847) 388-4770, with CONFIDENTIAL: ATTN D120 HR on the cover page.**