CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
EMPLOYEE AUTHORIZATION FOR CLARIFICATION/AUTHENTICATION OF MEDICAL CERTIFICATION

I, _____, authorize the City of Houston's health care representative to communicate with the health care provider named below for purposes of clarifying and/or verifying the authenticity of the FMLA medical certification dated _____/_____/_____, as specifically authorized under § 825.307 (a) of the Department of Labor Final Rule on the Family and Medical Leave Act of 1993. I understand that no additional information other than that indicated on the medical certification will be requested by the City's health care representative or given by my health care provider, and that my health care provider will only clarify and/or authenticate the medical certification.

_____ _____/_____/_____

Employee's Signature Date

Health Care Provider's Name: _____

(Please Print)

Telephone Number: (_____)_____-_____

Fax Number: (_____)_____-_____

Form I