FAMILY AND MEDICAL LEAVE ACT (FMLA)
HEALTH CARE PROVIDER CERTIFICATION FORM
BIRTH OF CHILD, ADOPTION OR FOSTER CARE PLACEMENT OF CHILD OR CARE FOR SUCH CHILD

Employee: Complete and submit the Family Medical Leave Request Form as soon as possible when the need for absence is known and at least 30 days in advance of the expected start of leave. This Provider Certification form is also needed to be submitted to the Human Resources Department for FMLA approval.

TO BE COMPLETED BY THE EMPLOYEE BIRTH PARENT (MOTHER OR FATHER), ADOPTIVE OR FOSTER CARE PARENT (MOTHER OR FATHER)

I request leave for the pregnancy or birth of my child or for placement of a child with me for adoption or foster care.

I request that the responsible health or birth care provider, adoption service provider or foster care authority provide the expected date of delivery or placement.

_____ _____
Employee Name Patient Name (if applicable)

Leave Reason: ☐ Birth of Child ☐ Adoption/Foster

Type of Leave Requested: ☐ Block of Time ☐ Intermittent

Start Date of Leave: _____ End Date of Leave: _____

TO BE COMPLETED BY THE HEALTH OR BIRTH CARE PROVIDER, ADOPTION SERVICE PROVIDER OR FOSTER CARE AUTHORITY

_____
Expected date of delivery, date of adoption placement or foster care placement

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order 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 GINA, includes an individual's family medical history, the 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.

PROVIDER INFORMATION

Name and Address of Provider: _____

_____

_____

_____
Signature of Provider

Please return form to: **FAX** 920-832-1534 Confidential-Attn: Monica Gosz
OR Mail to:
Outagamie County Government Center
Human Resources-4th floor
Confidential-Attn: Monica Gosz
320 S. Walnut St
Appleton, WI 54911