

**SECTION I – EMPLOYEE**

Give your health care provider this medical certification and ask him/her to complete and fax it to Outagamie County Human Resources by the due date on your Eligibility Notice (15 calendar days from the date requested). Follow up with your health care provider to confirm the medical certification was completed and faxed to Outagamie County Human Resources.

**Employee Name:****Employer Name:** Outagamie County**Employee Job Title:****Leave Type:****Block****Intermittent****Reduced Schedule****Dates Requested: Start date:****Last Date needed:****SECTION II - HEALTH CARE PROVIDER**

The above employee has requested leave under the FMLA. Please certify whether your patient has a serious health condition as the term is defined under the law. Please complete Parts A-C of this Section.

**Part A- Medical Information:** Limit your responses to the medical condition in which the employee is seeking leave. Your patient's condition must meet one or more of the definitions, summarized in number 1, which were created by the Family Medical Leave Act.

**(1) Select the Appropriate Description of Condition.** At least one reason must apply to qualify as a serious health condition under the FMLA and/or state law. ***All that apply, must be completed.***

- ☐ **Inpatient care:** The patient has been admitted in a hospital, hospice, or residential medical care facility; or any subsequent recovery or treatment in connection with such inpatient care
- ☐ **Permanent or long-term condition** for which the patient is under supervision of a health care provider and may be receiving active treatment (e.g. Alzheimer's, terminal stages of cancer)
- ☐ **Conditions requiring Multiple Treatments:** out of work to undergo multiple treatments and related recovery (e.g. chemotherapy treatments, restorative surgery)
- ☐ **Incapacity Plus Treatment:** Due to the condition, the patient is unable to work/perform job duties for more than three (3) full, consecutive calendar days, coupled with **(select one):**
  - ☐ Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; OR
  - ☐ At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, a course of prescription medication or therapy requiring special equipment
- ☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: \_\_\_\_\_
- ☐ **Chronic Conditions:** which requires periodic visits for treatment by a health care provider at least twice a year and may cause episodic incapacity or flare-ups or would cause periods of reoccurrence without treatment (e.g. diabetes, asthma, migraine headaches)
- ☐ **None of the Above:** The patient does not have a qualifying serious health condition.

**(2)** Briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. Such explanation may include symptoms, diagnosis, hospitalization, referrals or any regimen of continuing treatment such as the use of specialized equipment. (e.g., use of nebulizer, dialysis)

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**Part B- Amount of Leave Needed:** Consider all dates the patient has been or will be unable to work by completing the section below. The type of leave and dates requested by the patient are listed on page 1. At least one section, and all that apply, must be completed. Your answer should be your **best estimate** based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; **Answers of "unknown, lifetime or indeterminate" may result in an outreach call for clarification.**

☐ **Continuous Leave:** Patient is unable to work for a continuous block of time

Start date of leave: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (mm/dd/yyyy)

Estimated end date of incapacity: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (mm/dd/yyyy)

☐ **Intermittent Leave:** Patient is able to work but needs occasional time off for irregular absences  
**\*\*Also provide your best estimate of how often (frequency) and how long (duration) the appointments/treatments and episodes of incapacity will likely last.**

Start date for leave or initial appointment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (mm/dd/yyyy)

Estimated end date of leave: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (mm/dd/yyyy)

1. **Appointments/Treatments:** Will the patient need to miss work for appointments or treatment?

☐ No ☐ Yes- Please answer questions regarding Frequency and Duration

**Frequency:** What is the typical appointment or treatment schedule?

Up to \_\_\_\_\_ # times per ☐ week ☐ month ☐ year

**Duration:** How long do appointments/treatments, including subsequent recovery, typically last?

Lasting up to \_\_\_\_\_ # hours **OR** \_\_\_\_\_ # days

Please include the dates of any scheduled appointments and the time required for each appointment: \_\_\_\_\_

2. **Flare-ups/Episodes:** Will the patient need to miss work for episodes of incapacity/flare-ups of the health condition? ☐ No ☐ Yes- Please answer questions regarding Frequency and Duration

**Frequency:** How often may these episodes occur?

Up to \_\_\_\_\_ # times per ☐ week ☐ month ☐ year

**Duration:** What is a typical length of time needed to miss work for an episode?

Lasting up to \_\_\_\_\_ # hours **OR** \_\_\_\_\_ # days



FAMILY AND MEDICAL LEAVE ACT (FMLA)  
HEALTH CARE PROVIDER CERTIFICATION FORM  
**EMPLOYEE'S SERIOUS HEALTH CONDITION**

☐ **Reduced Schedule Leave:** Patient needs to be working a reduced schedule or taking regularly scheduled absences.

Start date of the reduced schedule \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

Last date of the reduced schedule \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

How many hours per day *can* the patient work? \_\_\_\_\_

On which days of the week *can* the patient work (ex: M, W, F,)? \_\_\_\_\_

**Part C- Health Care Provider Information and Signature:** Provide your area of practice or specialization. Health care providers must possess authorized credentials to certify a leave of absence under the FMLA, state and/or company leave.

Health Care Provider's Name: \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax :(\_\_\_\_) \_\_\_\_\_

Signature of medical provider: \_\_\_\_\_ Date: \_\_\_\_\_

Return the completed form via fax to Outagamie County Human Resources at the fax number listed below:

**Outagamie County Contact: Monica Gosz, Employee Leave Administrator**

**Phone:** 920-832-2016

**Fax:** 920-832-1534

**E-mail:** [monica.gosz@outagamie.org](mailto:monica.gosz@outagamie.org)

**Address:** Outagamie County Government Center  
320 S. Walnut St.  
Human Resources-4<sup>th</sup> floor  
Appleton, WI 54911

***Gina prohibits employers from requesting genetic information.***

**Genetic Information Nondiscrimination Act of 2008 Notification**

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 an individual or family member of the individual, except as specifically allowed by this law including, but not limited, to when the employee requests leave for a family member's health condition to (1) document appropriate use of sick leave; and (2) where "family medical history" is required to the extent necessary to make the medical certification complete and sufficient under the FMLA and WFMLA.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information unless it meets the family member exceptions noted above.

'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.