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

SECTION I - EMPLOYEE

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

Employee Name: **Employer Name:** Outagamie County

Name of the Family Member for whom you will provide care:

What is the relationship of the family member to you? The family member is your:
☐ Spouse ☐ Parent ☐ Child, under age 18 ☐ Parent-in-law (WI FML only)
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Briefly describe the care you will provide to your family member: *(check all that apply)*
☐ Assistance with basic medical, hygienic, nutritional or safety needs ☐ Transportation
☐ Physical Care ☐ Psychological Comfort ☐ Other:

Leave Type Requested: ☐ Block ☐ Intermittent ☐ Reduced Schedule

Dates Requested: Start date: **Last Date needed:**

SECTION II – HEALTH CARE PROVIDER

A family member of your patient has requested leave under the FMLA to care for your patient. Please certify whether your patient has a serious health condition as the term is defined under the law. Your patient's condition must meet one or more of the definitions, summarized in Number 4, which were created by the Family Medical Leave Act. Please complete Parts A-C.

PART A- Medical Information: Limit your response to the medical condition for which the employee is seeking FMLA. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.**

(1) Patient's Name: _____

(2) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)*.

_____

_____

(3) 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)*

_____

_____

(4) 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

☐ **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.

Part B- Amount of Leave Needed: Consider all dates the family member will need to miss work because they are needed to care for your patient when completing the section below. The type of leave and dates requested by the employee 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.*** **After completing Part B, please complete Part C.**

☐ **Continuous Leave:** Patient is in need of care by the family member for a single, continuous period of time.

Start date of leave: _____ / _____ / _____ (MM/DD/YYYY)

Estimated end date of incapacity: _____ / _____ / _____ (MM/DD/YYYY)

☐ **Intermittent Leave:** The patient's illness or injury requires this family member to take occasional time off work 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 (numbers 1 and 2 on page 3 of this form).**

Start date for leave or initial appointment: _____ / _____ / _____ (MM/DD/YYYY)

Estimated end date of leave: _____ / _____ / _____ (MM/DD/YYYY)

(1) Appointments/Treatments: Will the family member need to miss work for appointments or treatments?

☐ 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 family member need to miss work to care for the patient during 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

☐ **Reduced Schedule Leave:** The patient's condition requires their family member to work on a FIXED part-time schedule or to take predictable regularly scheduled absences to care for them.

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. Please then send using the contact information below.

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: **920-832-1534**

For any questions please contact: Monica Gosz, Employee Leave Administrator, Outagamie County

Phone: 920-832-2016 **E-mail:** monica.gosz@outagamie.org

Address: Outagamie County Government Center
Human Resources-4th floor
320 S. Walnut St.
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.