Print Form

UNIVERSITY OF WISCONSIN SYSTEM

CERTIFICATION BY HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

(FAMILY AND MEDICAL LEAVE ACT)

SECTION 1: For completion by the EMPLOYER	
Name of UW Institution: UW- Superior	
Name of Employer Contact: Peggy Fecker, Director of Human Resources	
Address of Employer: PO Box 2000, Belknap & Catlin, Superior, WI 54880	
Employer Contact Phone: 715/394-8365	Fax: 715/394-8171
Employer Contact Email: pfecker@uwsuper.edu	

SECTION 2: For completion by the EMPLOYEE	
INSTRUCTIONS to the EMPLOYEE: Please complete Section 2 before giving this form to your family member or his/her medical provider. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.	
Name of Employee:	
Name of family member for whom you will provide care:	
Relationship of family member/patient to you:	
Describe care you will provide to your family member and estimate leave needed to provide care:	
Employee Signature: _____	Date: _____

SECTION 3: For completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed in Section 2 has requested leave under the FMLA to care for your patient. Please answer all questions relative to the patient listed in Section 2 as fully and completely as possible. There are questions that require answers about the frequency or duration of a condition or treatment. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Please be sure to sign the second page of the form.

Part A: MEDICAL FACTS

1. Does the patient have a serious health condition?

☐ Yes (go to #2) ☐ No (provide signature an return to employer listed in Section 1)

* Wisconsin's Family and Medical Leave law (s. 103.10, Wis. Stats.) defines a "serious health condition" as: A disabling physical or mental illness, injury, impairment or condition involving either: 1) inpatient care in a hospital, or 2) outpatient care that requires continuing treatment or supervision by a health care provider.

2. Approximate begin date of condition:

3. Probable duration of condition:

4. Date(s) you treated the patient for condition:

5. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

6. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (e.g. symptoms, diagnosis, continuing treatment, use of specialized equipment):

Part B: AMOUNT OF CARE NEEDED

1. Will the patient be incapacitated for a single continuous period of time? ☐ No ☐ Yes

   If yes, estimate begin and end dates for the period of incapacity:

   During this time, will the patient need care? ☐ No ☐ Yes

   If yes, please explain the care needed by the patient:

2. Will the patient require follow-up treatments, including time for recovery? ☐ No ☐ Yes

   If yes, estimate treatment schedule, including dates of follow-up appointments and time required for each appointment, including any recovery period:

   If yes, please explain the care needed by the patient:

3. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

   Based on the patient's medical history and condition, please estimate frequency and possible duration of flare-ups within the next six months:

   Does the patient need care during these flare-ups? ☐ Yes ☐ No

   If yes, please explain the care needed by the patient:

Name of Health Care Provider:	
Health Care Provider Business Address:	
Telephone Number:	Fax:
Type of Practice/Medical Specialty:	
Signature of Health Care Provider: _____	**Date: _____**

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