UNIVERSITY OF WISCONSIN-MADISON
CERTIFICATION FOR FAMILY OR MEDICAL LEAVE

(This form is to be completed by the certified treating physician, practitioner or counselor) **CONFIDENTIAL MEDICAL FORM**

EMPLOYEE'S NAME:	**PATIENT'S NAME (If other than employee):**

1. I certify that ____

☐ Does have a *serious health condition** and qualifies under the category checked below:

1)_____ 2)_____ 3)_____ 4)_____ 5)_____ 6)_____

☐ Does not have a *serious health condition.** (provide signature and return form to address listed)

**Refer to the attached sheet which describes what is meant by a "serious health condition" under the Family and Medical Leave Act.*

2. Patient was seen by me and treated for this serious health condition on the following dates:

3. Describe the medical facts regarding the serious health condition that impede the employee's ability to work or requires the employee to care for the patient:

4. **Duration**

A. Date condition commenced: __________ Probable duration of condition: ____________

<u>If need is for full-time leave, complete 4B. If need is for intermittent or part-time leave, complete number 6 and number 7 (if applicable) on backside of this form.</u>

B. Probable duration of patient's inability to work, attend school, or perform other regular daily activities: ______________________________ through_______________________________

5. **To be completed only if category 3 (pregnancy) or category 4 (chronic conditions) was checked as the serious health condition in Section 1.**
State the likely duration and frequency of episodes of inability to work, attend school or perform other regular activities.

OVER

This section is to be completed only if the request is for intermittent or part-time leave for the employee.
6. If the absence is due to the **employee's own health condition:** (A) Provide a medical recommendation for the amount of leave, e.g., hours/day, days/week, etc. (B) Provide a list of the job functions the employee is unable to perform, if any, due to the medical condition. (The employer or employee should supply you with information about the essential functions.)
7. If the absence is due to the employee or family member's treatment, provide actual or estimated dates of treatment.

Physician/Practitioner Signature Date

Physician/Practitioner Name (Please print)

Physician Telephone

Physician/Practitioner Address

Please return completed, signed form to the person authorized to retain confidential medical information (DDR) at the following address:

(Use this area if stamping the address)

Attachment to University of Wisconsin-Madison Certification for Family or Medical Leave

A *"Serious Health Condition"* means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care
   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment
   A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
   a. **Treatment**[1] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

   b. **Treatment** by a health care provider on **at least one** occasion which results in regiment of continuing **treatment**[2] under the supervision of a health care provider.

3. Pregnancy
   Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments
   A chronic condition which:

   a. Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
   b. Continues over an **extended period of time** (including recurring episodes of a single underlying condition);
   c. May cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision
   A period of incapacity which is **permanent** or **long-term** due to a condition for which treatments may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)
   Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injuries, or for a condition that **would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), kidney disease (dialysis).

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[1]Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[2]A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.