WISCONSIN
UNIVERSITY OF WISCONSIN-MADISON

CERTIFICATION OF FAMILY AND MEDICAL LEAVE
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

For Office Use Only
Person ID: _____
ACSD: _____
UDDS:_____
Date Received:_____

SECTION I: For Completion by the EMPLOYEE

Employee's Name:	**Date of Birth**
Job Title:	**Department/Unit:**
Name of Supervisor:	

INSTRUCTIONS to the EMPLOYEE:

Please give this form to your medical provider for completion. The Family and Medical Leave Act (FMLA) permits an employer to require that you submit a timely, complete and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. 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.

For more information on the FMLA, visit the Department of Labor's website at https://www.dol.gov/whd/fmla/

For more information on the WFMLA, visit the Wisconsin Department of Workforce Development website at https://dwd.wisconsin.gov/er/civil_rights/fmla/

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the TREATING SPECIALIST: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts, paying attention to the specific points listed here. Limit your responses to the condition for which the employee is seeking leave. ***Please be sure to sign the last page**.

- Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient.

Treating Specialist's name: _____ (please print)

Treating Specialist's business address: _____

_____

Type of practice/ Medical specialty: _____

Telephone (_____) _____ Fax: (_____) _____

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

_____

_____

_____

PART A: MEDICAL FACTS

1. I certify that _____

☐ Does have a *serious health condition (described on page 4)** and qualifies under the category checked below:

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

☐ Does not have a *serious health condition (described on page 4).** Provide signature and return form to address listed.

**Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act.*

2. Approximate date condition commenced: _____

Date(s) you treated the patient for this condition: _____

Probable duration of condition*: _____

*** Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. You may be requested to clarify your answer if these terms are used.**

3. If the medical condition is pregnancy, indicate expected delivery date: _____

4a. Describe the medical facts regarding the serious health condition that impede the employee's ability to work (e.g. symptoms, diagnosis, or any regimen of continuing treatment):

_____

_____

4b. Is the employee unable to perform any of his/her job functions due to the condition? YES___ NO ___

If YES, explain the specific limitations preventing the employee from performing his/her job functions, and identify the job functions the employee is unable to perform (if necessary, use additional space on the last page of the form):

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED
(Continuous, Intermittent, or a Reduced Work Schedule)

Continuous Leave

5a. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? YES _____NO _____

If YES: Estimated Begin Date: _____

Estimated End Date _____ **OR** Date of Reevaluation:_____

5b. Will it be medically necessary for the employee to attend follow-up treatment appointments at the end of the continuous leave?

YES_____NO _____ Unable to determine at this time _____

If YES, please complete the intermittent leave section below.

Intermittent Leave

Note: Please include leave needed for appointments, including travel time, and other medically necessary leave

6. Will the condition make it medically necessary for the employee to take intermittent leave?
YES_____ NO _____

If YES, based upon the patient's medical history and your knowledge of the medical condition, estimate the **frequency** of the episodes/flare-ups **and** the **duration** of related incapacity that the patient may have over the next 6 months (E.g., 1 episode every 3 months lasting 1-2 days):

Estimated Begin Date: _____ Estimated End Date or Date of Reevaluation: _____

Frequency of episodes: _____ times per **week or month** (please circle one)

Duration of incapacity: _____ hours per episode **OR** _____ days per episode

Reduced Work Schedule

7. Will the employee need a reduced work schedule? YES_____NO _____

If YES, estimate leave needed:

Estimated begin date:_____ Estimated End Date or Date of Reevaluation: _____

Leave Needed: _____ hours per day **OR** _____ days per week

ADDITIONAL INFORMATION (Please identify question number when responding):

_____

_____

_____ _____

Signature of Treating Specialist **Date**

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. To comply with the law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined be GINA, includes an individual's family medical history, the results of an individual's or family members 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.

Attachment to University of Wisconsin-Madison Certification for Family and Medical Leave
Family and Medical Leave Act of 1993 Section 825.112 Qualifying Reasons for Leave

A *"Serious Health Condition"* means an illness, injury, impairment, or physical or mental condition that involves one of the following: A serious health condition involving continuing treatment by a health care provider includes any one or more 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. Incapacity and Treatment
   A period of incapacity of **more than three consecutive, full calendar days**, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
   a. **Treatment[1] two or more times,** within 30 days of the first day of incapacity, unless extenuating circumstances exist, 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 a regimen of continuing **treatment[2]** under the supervision of a health care provider.

The requirement in (a) and (b) of this section for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.

Whether additional treatment visit or a regimen of continuing treatment is necessary within the 30-day period shall be determined by the health care provider.

The term "extenuating circumstances" in (a) of this section means circumstances beyond the employee's control that prevent the follow-up visit from occurring as planned by the health care provider. Whether a given set of circumstances are extenuating depends on the facts. For example, extenuating circumstances exist if a health care provider determines that a second in-person visit is needed within the 30-day period, but the health care provider does not have any available appointments during that time period.

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

4. Chronic Conditions
   Any period of incapacity or treatment for such incapacity due to a chronic serious health condition.
   A chronic serious health condition is one which:

   a. Requires **periodic visits** (defined as at least twice a year) 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 treatment 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 there from) 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, full calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), or kidney disease (dialysis).

Absences attributable to incapacity under (3) or (4) qualify for FMLA leave even though the employee or the covered family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than three consecutive, full calendar days. For example, an employee with asthma may be unable to report for work due to the onset of an asthma attack or because the employee's health care provider has advised the employee to stay home when the pollen count exceeds a certain level. An employee who is pregnant may be unable to report to work because of severe morning sickness.

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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.