City of De Pere

Certification of Health Care Provider for (FMLA)

RETURN THIS FORM TO HUMAN RESOURCES BY:

SECTION I: For Completion by the EMPLOYEE

TO BE COMPLETED BY THE EMPLOYEE: Please complete Section I before giving this form to the medical provider.
Employee's Name (First, Middle, Last)
Patient's Name (if different than employee) **Date of Birth:**
I certify that the health care provider for the patient listed below, may disclose medical information in regards to my leave of absence request from Employment as outlined in the Family and Medical Leave Act of 1993, as well as under State of Wisconsin FMLA laws. _____ **Employee Signature:**

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The above employee has requested leave under the FMLA. Answer, fully and completely, all applicable parts below as they pertain to your patient (as named above**).** Several questions seek a response as to the frequency or duration of a condition, treatment, etc. 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. Limit your responses to the condition for which the employee is seeking leave. **Be as specific as you can**. **Please complete and mark items below as applicable. Please be sure to sign the form on the last page.**

Name of Health Care Provider (printed):	**Type of Practice / Medical Specialty:**
Name of Hospital or Clinic and Business Address:	**Phone:** **Fax:**
Name of Patient:	**Date of Birth:**

PART A: Medical Facts.

1. Please check the following, in relation to the employee;

   - ☐ Birth of Child;
   - ☐ Own Serious Health Condition;
   - ☐ Serious Health Condition of;
     - ☐ Child
     - ☐ Parent
     - ☐ Parent-in-law
     - ☐ Spouse
     - ☐ Domestic Partner

2. Approximate date condition commenced: _____ Probable duration of condition: _____

   a. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes ☐ No ☐

      If yes, dates of admission: _____

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

      _____

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

d. Was medication, other than over-the-counter medication, prescribed? Yes ☐ No ☐

e. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes ☐ No ☐

If yes, please list other providers name_____

3. Is the medical condition a pregnancy? Yes ☐ No ☐ If yes, expected delivery date: _____

4. Describe other relevant medical facts, if any, related to the condition (such as symptoms, diagnosis, or regimen of continuing treatment):

_____

_____

_____

_____

PART B: If the patient IS the EMPLOYEE, please complete the following. If not, please skip to Part C.

5. Is the employee unable to perform their job functions due to this medical condition? Yes ☐ No ☐

If yes, list job functions employee is unable to perform: _____

_____

_____

6. Will the employee be incapacitated for a single continuous period of time due to their medical condition, including any time for treatment and recovery? Yes ☐ No ☐

If yes, estimate the beginning and ending dates for the period of incapacity:

Beginning Date: _____ Ending Date: _____

7. Will the employee need to attend follow-up treatment appointments, or work part-time, or on a reduced schedule because of the employee's medical condition? Yes ☐ No ☐

a. If yes, are the treatments or the reduced hours medically necessary? Yes ☐ No ☐

b. Estimate the reduced work hours employee needs, if necessary:

_____hours per day _____days per week from _____ through _____

8. Will the condition cause episodic flare-ups, periodically preventing the employee from performing his/her job functions? Yes ☐ No ☐

a. Is it medically necessary for the employee to be absent from work during the flare-ups? Yes ☐ No ☐

If yes, explain: _____

b. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of 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):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

PART C: If the patient is NOT the employee, please complete.

9. 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).

_____

_____

_____

10. Will the patient be incapacitated for a single continuous period, including any time for treatment and recovery? Yes ☐ No ☐

If yes, please estimate the beginning and ending dates for the period of incapacity:

_____

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

11. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? Yes ☐ No ☐

a. Estimate hours patient needs care on an intermittent basis, if any:

_____hours per day _____days per week from _____ through _____

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

a. Estimate the frequency of 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)

Frequency: _____time(s) per_____week(s)_____month(s)

Durations: _____hour(s) or _____day(s) per episode

b. Does patient need care during flare-up episodes? Yes ☐ No ☐

Signature of Health Care Provider:	**Date:**

RETURN COMPLETED FORM TO THE PATIENT OR FAX/MAIL TO:

TRACY HOOD
HUMAN RESOURCES GENERALIST
CITY OF DE PERE
335 S. BROADWAY
CITY OF DEPERE, WI 54115

FAX: (920) 339-4049