UNIVERSITY OF WISCONSIN SYSTEM
CERTIFICATION BY HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION
(FAMILY AND MEDICAL LEAVE ACT)

SECTION 1: For completion by the EMPLOYER	
Name of UW Institution: UW Oshkosh	
Name of Employer Contact: Katelyn Fenner	
Address of Employer: 800 Algoma Blvd, Oshkosh, WI 54901	
Employer Contact Phone: (920) 424-3008	Fax: (920) 424-2021
Employer Contact Email: fennerk@uwosh.edu	
Employee's Job Title:	Regular Work Schedule:
Employee's Essential Job Functions:	
☐ Check if job description is attached	

SECTION 2: For completion by the EMPLOYEE
INSTRUCTIONS to the EMPLOYEE: Please complete Section 2 before giving this form to your 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/Patient:

SECTION 3: For completion by the HEALTH CARE PROVIDER
INSTRUCTIONS to the HEALTH CARE PROVIDER: 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 and 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. Use the information provided by the employer in Section 1 to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions? ☐ No ☐ Yes

   If yes, identify the job functions that employee is unable to perform:

7. 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 LEAVE NEEDED

1. Will the employee be incapacitated for a single continuous period of time? ☐ No ☐ Yes
   If yes, estimate begin and end dates for the period of incapacity:

2. Will the employee need follow-up treatment appointments or need to work part-time or on a reduced schedule due to medical condition? ☐ No ☐ Yes

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

   If applicable, estimate the part-time or reduced work schedule the employee needs:

   _____ hour(s) per day; _____ days per week from _____ through _____

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

   If yes, is it medically necessary for the employee to be absent from working during flare-ups? ☐ No ☐ Yes
   If yes, please explain:

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

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

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.