

**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-

Name of Employer Contact:

Address of Employer:

Employer Contact Phone:

Fax:

Employer Contact Email:

**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 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. 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: \_\_\_\_\_

## **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.