City of Madison
FAMILY / MEDICAL LEAVE OF ABSENCE
HEALTH CARE PROVIDER CERTIFICATION
Employee - Serious Health Condition

TO BE COMPLETED BY THE EMPLOYEE

I hereby authorize the Health Care Provider(s) to release the information requested below to:

CITY OF MADISON HUMAN RESOURCES DEPARTMENT

_____ _____

Employee Name (print or type) Date of Birth

_____

Employee Signature

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Today's Date:_____ Date Condition Commenced:_____

Please describe the **medical facts** supporting your certification of a serious health condition:_____

_____

_____

_____

Probable Duration of Condition:_____

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 employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. '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.

TREATMENT PRESCRIBED

Please describe the nature and duration of treatment, including the number and schedule of visits or treatments:

_____

_____

_____

_____

_____

_____

_____

PLEASE RESPOND TO THE FOLLOWING QUESTIONS

	Yes	No
Is inpatient hospitalization of the patient required?	☐	☐
Is employee able to perform the functions of the employee's position? Please respond after reviewing the job description as provided by the employer (attached, or, if none provided, after discussing with the employee).	☐	☐
Is it medically necessary for the employee to be off work?	☐	☐

If yes, please specify all that apply:

☐ Consecutive Leave: From:_____ (Date) to _____ (Date)

☐ Intermittent Leave: Please identify amount of leave that could reasonably be expected per month.

_____

☐ Reduced Schedule of Days/Hours (specify schedule below)

Date Leave to Begin:_____ Expected Duration of Leave:_____

_____

_____

HEALTH CARE PROVIDER INFORMATION

Name and Address of Health Care Provider:_____

_____

_____

_____

Telephone:_____ FAX:_____

Name of Physician or Practitioner:_____

Field of Specialization (if applicable):_____

Signature of Physician or Practitioner:_____

Please return form to:

CONFIDENTIAL-BENEFITS
HUMAN RESOURCES DEPARTMENT
215 MARTIN LUTHER KING JR BLVD STE 261
MADISON WI 53703
FAX 608-267-1115