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

TO BE COMPLETED BY THE EMPLOYEE

Employee Name:_____

Family Member Relation: ☐ Spouse ☐ Child ☐ Parent ☐ Parent-in-Law ☐ Domestic Partner ☐ Parent of Domestic Partner

I certify that the person who I am requesting FMLA leave to help care for is my spouse, child, parent, parent-in-law, domestic partner as defined in the Wisconsin Statutes 40.02(21c) or 770.01(1), or parent of my domestic partner. (Please see APM 2-21 for a more detailed definition of domestic partner.)

Employee Signature:_____

Please describe the care you will be providing:_____

_____

Please estimate the time period during which you will provide such care:_____

_____

Please describe the schedule by which you propose to take leave (check all that apply):

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

☐ Intermittent Leave (specify schedule below)

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

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

TO BE COMPLETED BY THE FAMILY MEMBER

I hereby authorize the Health Care Provider to release the information requested below.

_____ Name (print or type)

_____ Date of Birth

_____ Signature

_____ Today's Date

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Today's Date:_____

Please describe the **medical facts** supporting your certification of a serious health 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.

Date Condition Commenced:_____ Probable Duration of Condition:_____

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?	☐	☐
Does (or will) the patient require assistance for basic medical care, hygiene, nutritional needs, safety or transportation?	☐	☐
Do you believe the employee's presence is necessary or would be beneficial for the physical care or psychological comfort of the patient?	☐	☐

Please estimate the number of days per month the employee's presence would be beneficial if this request is for intermittent 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