SEND COMPLETED FORM DIRECTLY TO: **Dane County Employee Relations**
City-County Building, Room 418, 210 Martin Luther King Jr. Boulevard, Madison, WI 53703
PH (608) 266-4125 • FAX (608) 283-1571

HEALTHCARE PROVIDER CERTIFICATION

I confirm that...

NAME OF HEALTH CARE PROVIDER:	PATIENT'S NAME:	DANE COUNTY'S EMPLOYEE'S NAME: (If different)

EMPLOYEE: Please complete Section I before giving this form to your medical provider.

SECTION I. EMPLOYEE /PATIENT MEDICAL AUTHORIZATION & RELEASE,

I, _____hereby authorize and consent to my health care provider(s) who have provided medical care to me at any time for treatments related to my health condition described below, to disclose medical information to Dane County; attention Human Resources Manager; City-County Building, Rm. 418, 210 Martin Luther King, Jr. Blvd., Madison, WI 53703. I understand the purpose or need for this disclosure is to assist Dane County in ascertaining the reasons for my absence from work and/or determining my ability to perform my job. This consent authorizes the Human Resources Manager to confer with my health care provider(s) regarding the health condition. This consent also authorizes the Human Resources Manager to review any information received pursuant to this release with any or all of the following: my department head/supervisor, Risk Management and Corporation Counsel. This authorization shall be valid for one year from the date shown below or for the term of the FMLA, whichever is shortest. Employee may revoke this release by notifying Employee Relations in writing.

Dated this _____ day of _____, _____. _____ Signature

❑ **I have chosen not to sign the release.**

SECTION II. FOR COMPLETION BY THE HEALTH CARE PROVIDER (COMPLETE FOR ALL FMLA REQUESTS):

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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. Please be sure to sign the form on the last page.

A. The patient is one of the following (check the appropriate box):

- ❑ An employee of Dane County;
- ❑ The spouse/domestic partner of the Dane County employee;
- ❑ The son or daughter of the Dane County employee; (under age 18? ☐ yes ☐ no)
- ❑ The parent of the Dane County employee.

B. Is under my care for a serious health condition* involving (check the appropriate box):

- ❑ Inpatient care in a hospital, hospice or residential medical facility; and/or
- ❑ Any period of absence which requires:
  - absence from work, school or other regular activities;
  - absence for more than three (3) calendar days; and
  - continuing treatment or supervision by a health care provider;
- ❑ Continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that it may result in a period of incapacity of more than (3) calendar days; or
- ❑ Pre-natal care/maternity leave. Estimated due date:_____

*requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider; b) Continues over an extended period to time (including recurring episodes of a single underlying condition; and c) May cause episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, or epilepsy).

SECTION II (CONTINUED)

C. Accordingly, I certify that: **(this section must be completed for all FMLA requests)**

1. The serious health condition commenced on _____ and has a probable duration through_____.
2. The patient was first seen by me relative to, and treated for, this serious health condition on_____.
3. I have provided care to the patient on the following date(s). (List all dates of treatment or supervision, including future appointments needed/scheduled with you or another physician):

   _____

   _____

4. The serious health condition is as follows:

   _____

   _____

5. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes
6. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes
7. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes
8. Was the patient referred to other health care provider(s) for evaluation or treatments (e.g., physical therapist)? ☐ No ☐ Yes. If so, state the nature of such treatments and expected duration of treatment.

   _____

   _____

SECTION III. COMPLETE IF THE PATIENT IS AN EMPLOYEE:

The serious health condition must render the employee unable to perform the functions of his/her position. This means the employee is unable to work at all or is unable to perform the essential functions of the position. Use the information provided in the job description. If there is no description attached answer the questions based upon the employee's own description of his/her job functions.

A. I have read the employee's job description and am aware of the job functions required for this employee to perform the functions of the position. The following functions may be performed by the employee:

YES	NO	
☐	☐	Standing for 30 minutes or less
☐	☐	Standing for more than 30 minutes but less than 2 hours (with or without breaks)
☐	☐	Standing for more than 2 hours (with or without breaks)
☐	☐	Sitting for 30 minutes or less
☐	☐	Sitting (with or without breaks) for more than 30 minutes but less than 2 hours
☐	☐	Sitting (with or without breaks) for more than 2 hours
☐	☐	Walking short distances (20 yards)
☐	☐	Arm movement (if limited please note below)
☐	☐	Lifting 20 or more pounds (if limited please note below)
☐	☐	Lifting less than 20 pounds (if limited please note below)
☐	☐	Talking

B. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

SECTION IV. COMPLETE IF THE EMPLOYEE OR FAMILY MEMBER WILL NEED INTERMITTENT/REDUCED LEAVE:

A. If the employee requires intermittent or reduced leave (leave that reduces the employee's hours per work week or workday) which is medically necessary, please describe why the intermittent or the reduced leave is medically necessary, the dates on which treatment is expected, and the expected frequency and duration of the treatment and leave.

1. Why is intermittent or reduced leave medically necessary:_____

_____

2. The likely frequency of episodes of incapacity? _____times per _____week(s) _____month(s) (e.g. weekly, monthly, every 6 months).

3. The likely duration of these episodes of incapacity? _____hours _____day(s) per episode (e.g. 1 hour, 2 hours, half day).

If you provide "unknown" as an answer to either question above, this certification will be incomplete, we will not be able to process the employee's request for leave, and the employee will be required to obtain the information from you or run the risk of having his/her leave request denied.

4. During what portion of the day is the period or episode of incapacity likely to occur (e.g. morning, afternoon, evening, night time, sleeping hours)?_____

5. During the period or episode of incapacity, will the employee be able to work at all doing any job (whether with us, for another employer, or in his/her own business)? ..... ❑ YES ❑ NO
If no, please explain your answer in detail:_____

_____

6. Is the employee limited to working 40 or less hours per week (exclusive of breaks and other time off of active work)?..... ❑ YES ❑ NO

7. Is the employee able to work overtime? ..... ❑ YES ❑ NO
If no, please explain your answer in detail:_____

_____

8. Is a period or episode of incapacity more likely to occur on any particular day of the week than others? ..... ❑ YES ❑ NO
If yes, what day(s) of the week and explain why:_____

_____

SECTION V. COMPLETE IF THE PATIENT IS THE SPOUSE, DOMESTIC PARTNER, SON, DAUGHTER OR PARENT OF THE EMPLOYEE:

The serious health condition of such individual must require that the employee is needed to care for such individual. A serious health condition for such individual is any condition that affects an individual's ability to engage in normal daily activities.

A. The employee will be needed to care for the spouse, domestic partner, son, daughter or parent for approximately the following dates and period of time:

_____

_____

B. Describe the care to be provided by employee:

_____

_____

C. If the employee requires intermittent or reduced leave (leave that reduces the employee's hours per week or work day) to care for the employee's spouse, domestic partner, son, daughter or parent,
please complete section IV above.

D. Is the patient incapable of performing certain activities of daily living assistance form the employee? If so, please indicate which of the following may not be performed by the patient because of the patient's condition (check as appropriate):

❑ Personal grooming ❑ Bathing ❑ Personal hygiene ❑ Dressing ❑ Cooking & cleaning

❑ Using a telephone ❑ Driving/Attending Dr's. appts. ❑ Shopping ❑ Eating

❑ Other (please specify)_____

SECTION VI. QUESTIONS SPECIFIC TO THIS PATIENT (for employer use only):

_____

_____

_____

_____

_____

SECTION VII. PHYSICIAN'S INFORMATION

Dated this _____ day of _____, _____.

_____ _____
Signature of Health Care Provider Telephone Number

_____ _____
Please print name Fax Number

_____
Address City/State/Zip

Genetic Information Nondiscrimination Act of 2008 (GINA) Notice

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. GINA does permit employers to request or require genetic information when an employee takes leave to care for his/her own health condition. 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 in connection with a leave for your own health condition.
'Genetic Information" as defined by GINA includes an individual's family medical history, the result 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 of an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.