

UNIVERSITY OF WISCONSIN-MADISON  
CERTIFICATION OF FAMILY AND MEDICAL LEAVE  
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

For Office Use Only Person ID: _____ UDDS: _____
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**SECTION I: For Completion by the EMPLOYEE**

<b>Employee's Name:</b>	<b>Job Title:</b>
<b>Department/Unit:</b>	<b>Name of Supervisor:</b>

**INSTRUCTIONS to the EMPLOYEE:** Please give this form to your medical provider for completion. The Family and Medical Leave Act (FMLA) permits an employer to require that you submit a timely, complete and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. 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.

For more information on the FMLA, visit the Department of Labor's website at <http://www.dol.gov/compliance/laws/comp-fmla.htm>

For more information on the WFMLA, visit the Wisconsin Department of Workforce Development website at [http://www.dwd.state.wi.us/er/family\\_and\\_medical\\_leave/default.htm](http://www.dwd.state.wi.us/er/family_and_medical_leave/default.htm)

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**SECTION II: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the TREATING SPECIALIST:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts, paying attention to the specific points listed here. Limit your responses to the condition for which the employee is seeking leave.

**\*Please be sure to sign the last page.**

- 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. You may be requested to clarify your answer if these terms are used.

Treating Specialist's name: \_\_\_\_\_ (please print)

Treating Specialist's business address: \_\_\_\_\_  
\_\_\_\_\_

Type of practice/ Medical specialty: \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

PART A: MEDICAL FACTS

1. I certify that \_\_\_\_\_

Does have a *serious health condition* (described on page 4)\* and qualifies under the category checked below:

1)\_\_\_\_\_ 2)\_\_\_\_\_ 3)\_\_\_\_\_ 4)\_\_\_\_\_ 5)\_\_\_\_\_ 6)\_\_\_\_\_

Does not have a *serious health condition* (described on page 4).\* Provide signature and return form to address listed.

\*Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act.

2. Approximate date condition commenced: \_\_\_\_\_

Date(s) you treated the patient for this condition: \_\_\_\_\_

Probable duration of condition\*: \_\_\_\_\_

**\* Be as specific as you can;** terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. You may be requested to clarify your answer if these terms are used.

If for pregnancy, indicate expected delivery date: \_\_\_\_\_

3. Describe the medical facts regarding the serious health condition that impede the employee's ability to work (e.g. symptoms, diagnosis, or any regimen of continuing treatment):

\_\_\_\_\_  
\_\_\_\_\_

4. Is the employee unable to perform any of his/her job functions due to the condition? YES \_\_\_ NO \_\_\_

If YES, explain the specific limitations preventing the employee from performing his/her job functions, and identify the job functions the employee is unable to perform (if necessary, use additional space on the last page of the form):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PART B: AMOUNT OF LEAVE NEEDED (Continuous, Intermittent, or a Reduced Work Schedule)

**Continuous Leave**

5a. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES: Estimated Begin Date: \_\_\_\_\_ Estimated End Date or Date of Reevaluation: \_\_\_\_\_

Name of Employee \_\_\_\_\_

5b. Will it be medically necessary for the employee to attend follow-up treatment appointments at the end of the continuous leave?

YES \_\_\_\_\_ NO \_\_\_\_\_ Unable to determine at this time \_\_\_\_\_

If YES, estimate treatment schedule, if any, including the estimated frequency of appointments and the estimated time required for each appointment, including any recovery period:

\_\_\_\_\_  
\_\_\_\_\_

**Intermittent Leave**

6. Will the condition make it medically necessary for the employee to take intermittent leave?

YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of the flare-ups and the duration of related incapacity that the patient may have over the next 6 months (E.g., 1 episode every 3 months lasting 1-2 days):

Estimated Begin Date: \_\_\_\_\_ Estimated End Date or Date of Reevaluation: \_\_\_\_\_  
Frequency: \_\_\_\_\_ times per week **OR** \_\_\_\_\_ times per month

Duration: \_\_\_\_\_ hours per episode **OR** \_\_\_\_\_ days per episode

**Reduced Work Schedule**

7. Will the employee need a reduced work schedule? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, estimate the part-time or reduced work schedule the employee needs, if any:

Estimated begin date: \_\_\_\_\_ Estimated End Date or Date of Reevaluation: \_\_\_\_\_

Frequency: \_\_\_\_\_ hours per episode **OR** \_\_\_\_\_ days per week

**ADDITIONAL INFORMATION** (Please identify question number when responding):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Treating Specialist**

\_\_\_\_\_  
**Date**

Please return completed, signed form to the person authorized to retain confidential medical information (DDR) at the following address:

\_\_\_\_\_**Julie Gau**\_\_\_\_\_

\_\_\_\_\_**21 N Park St, Suite 5101**\_\_\_\_\_

\_\_\_\_\_**Madison, WI 53715**\_\_\_\_\_

**FAX: 608-265-3335**

**Attachment to University of Wisconsin-Madison Certification for Family and Medical Leave**  
*Family and Medical Leave Act of 1993 Section 825.112 Qualifying Reasons for Leave*

A “*Serious Health Condition*” means an illness, injury, impairment, or physical or mental condition that involves one of the following: A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

1. Hospital Care

**Inpatient care** (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Incapacity and Treatment

A period of incapacity of **more than three consecutive, full calendar days**, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- a. **Treatment<sup>1</sup> two or more times**, within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- b. **Treatment** by a health care provider on **at least one** occasion which results in a regimen of continuing **treatment<sup>2</sup>** under the supervision of a health care provider.

The requirement in (a) and (b) of this section for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.

Whether additional treatment visit or a regimen of continuing treatment is necessary within the 30-day period shall be determined by the health care provider.

The term “extenuating circumstances” in (a) of this section means circumstances beyond the employee’s control that prevent the follow-up visit from occurring as planned by the health care provider. Whether a given set of circumstances are extenuating depends on the facts. For example, extenuating circumstances exist if a health care provider determines that a second in-person visit is needed within the 30-day period, but the health care provider does not have any available appointments during that time period.

3. Pregnancy or Prenatal Care

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions

Any period of incapacity or treatment for such incapacity due to a chronic serious health condition.

**A chronic serious health condition** is one which:

- a. Requires **periodic visits** (defined as at least twice a year) 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 of time** (including recurring episodes of a single underlying condition);
- c. May cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

A period of incapacity which is **permanent** or **long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injuries, or for a condition that **would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), or kidney disease (dialysis).

Absences attributable to incapacity under (3) or (4) qualify for FMLA leave even though the employee or the covered family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than three consecutive, full calendar days. For example, an employee with asthma may be unable to report for work due to the onset of an asthma attack or because the employee's health care provider has advised the employee to stay home when the pollen count exceeds a certain level. An employee who is pregnant may be unable to report to work because of severe morning sickness.

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<sup>1</sup>Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

<sup>2</sup>A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.