

UNIVERSITY OF WISCONSIN-MADISON  
CERTIFICATION OF FAMILY AND MEDICAL LEAVE  
FOR FAMILY MEMBER'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 complete page 1 before giving this form to your family member or his/her medical provider. 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 to care for a covered family member with a 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)

Name of family member for whom you will provide care: \_\_\_\_\_  
First Last

Relationship of family member to you (includes domestic partner\*-WFMLA only): \_\_\_\_\_

If family member is your son or daughter, date of birth: \_\_\_\_\_

Describe the care you will provide to your family member, and estimate the amount of leave needed to provide care:

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\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\*To qualify, an employee must have completed the Declaration of Domestic Partner form available online at <http://www.provost.wisc.edu/docs/ddpf.pdf>

**SECTION II: For Completion by the TREATING SPECIALIST**

**INSTRUCTIONS to the TREATING SPECIALIST:** The employee listed on page one has requested leave under the FMLA to care for your patient. 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 5)\** and qualifies under the category checked below:

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

Does not have a *serious health condition (described on page 5)\**. Provide signature on page 4 and return form to address listed.

*\*Page 5 which 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.

3. Describe the relevant medical facts, if any, related to the condition which requires the employee to care for the patient (e.g. symptoms, diagnosis, or any regimen of continuing treatment):

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

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

**PART B: AMOUNT OF CARE NEEDED:** When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygiene, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? YES \_\_\_\_\_ NO \_\_\_\_\_

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

During this time, will the patient need care? YES \_\_\_\_\_ NO \_\_\_\_\_ (if NO, go to question #5)

If YES, explain the care needed by the patient:

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5. Will the patient require follow-up treatments, including any time for recovery?

YES \_\_\_\_\_ NO \_\_\_\_\_ (if NO, go to question #6)

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

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If YES, explain the care needed by the patient:

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6a. Will the condition periodically prevent the patient from participating in normal daily activities?

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

If YES, does the patient need care during these periods of incapacity? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, explain the care needed by the patient: \_\_\_\_\_

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

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

Frequency: \_\_\_\_\_ times per week     **OR**     \_\_\_\_\_ times per month

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

**\*Please note: The determination of whether intermittent leave is appropriate for the employee caring for your patient will be determined based on the information listed above.**

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

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

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

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

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**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.