

Employee Completes Section A

A. Leave Request Information

1. _____
Employee Name Family Member (First) Middle Last Name

2. Relationship of Family Member: (Check one box) Spouse Parent Spouse's Parent Child

If family member is your son or daughter, list his/her date of birth: _____

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

Employee Signature

Date

Healthcare Provider Completes Sections B, C, D & E

Instructions To Healthcare Provider: **The above family member of your patient has requested leave under the FMLA (Family and Medical Leave Act). Answer fully and completely all applicable parts. Several questions seek a response to the frequency or duration of condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience, and examination of the patient. Be specific as you can since 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.**

B. Medical Facts

1. Patient Name: _____
First Middle Last

2. Approximate date condition commenced: _____

3. Probable duration of condition: _____

4. **Complete below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes If yes, dates of admission: _____

Date(s) you treated patient for condition: _____

Was medication, other than over-the-counter medication prescribed? No Yes

Was patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)?

No Yes If yes, state nature of treatments and expected duration of treatments:

Will patient need treatment visits at least twice per year due to condition: No Yes

5. 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 regiment of continuing treatment such as use of specialized equipment): _____

C. Amount Of Care Needed: When answering these questions, keep in mind your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or provision of physical and psychological care.

1. Will patient be incapacitated for a single continuous period of time including time for treatment & recovery?
 No Yes If yes, estimate dates for period of incapacity:

Beginning Date: _____ Ending Date: _____

During this time, will the patient need care: No Yes

If yes, explain the care needed by the patient and why such care is medically necessary: _____

2. Will patient require follow-up treatments, including any time for recovery? No Yes

Estimate treatment schedule, including dates of scheduled appointments and time required for each appointment: _____

Explain care needed by patient, and why such care is medically necessary: _____

3. Will patient require care on an intermittent or reduced schedule basis, including time for recovery?

No Yes

Estimate the hours the patient needs care on an intermittent basis, if any

_____ Hour(s) per day _____ Days per week - From: _____ Through _____
Date Date

Explain care needed by patient and why such care is medically necessary: _____

4. Will condition cause episodic flare-ups periodically and prevent patient from participating in normal daily activities?

No Yes

Based on patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that patient may have over the next six months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ Times per _____ Week(s) OR _____ Month(s)

Duration: _____ Hours OR _____ Day(s) Per Episode

Does patient need care during these flare-ups? No Yes

Explain the care needed by patient and why such care is medically necessary: _____

D. Additional Information: Identify Question Number With Additional Answer

E. Healthcare Provider Information

Healthcare Provider Name (Print or Type) _____

Healthcare Provider's Signature _____ Date _____

Type of Practice/Medical Specialty: _____

Business Address _____

City, State, Zip Code _____ Phone Number _____ Fax Number _____

Please Fax To A Secure Fax 715-261-1463 OR Mail This Medical Certification To:
Marathon County Employee Resources Department
500 Forest St, Wausau, WI 54403