

## CERTIFICATION BY HEALTH CARE PROVIDER FOR FAMILY OR MEDICAL LEAVE

<b>EMPLOYEE'S NAME:</b>	<b>PATIENT'S NAME (if other than employee):</b>
<p><b>1. Does _____ have a serious health condition?*</b> (patient)</p> <p>____ YES (continue with #2)      ____ NO (provide signature and return form to address listed)</p> <p><b>*NOTE: Wisconsin's Family and Medical Leave law (s. 103.10, Wis. Stats.) defines a "serious health condition" as: A disabling physical or mental illness, injury, impairment or condition involving either: 1) inpatient care in a hospital, or 2) outpatient care that requires continuing treatment or supervision by a health care provider.</b></p>	
<b>2. Date condition commenced:</b>	
<b>3. Probable duration of condition:</b>	
<b>4. Specify medical facts regarding the serious health condition:</b>	
<b>5. Indicate the extent to which the employee is unable to perform his or her employment duties:</b>	

**Health Care Provider Name (please print):** \_\_\_\_\_

**Type of Practice / Medical Specialty:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

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

\_\_\_\_\_  
**Health Care Provider Signature**

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

Please return completed, signed form to the following address:

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