WAUKESHA COUNTY
FMLA Health Care Provider Certification Form
HR 1500-C

Dept of Administration-Human Resources Division
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INSTRUCTIONS TO THE EMPLOYEE: Please complete this section before giving this Form to the health care provider. Failure to provide a complete and sufficient Health Care Provider Certification Form may result in a denial of your FMLA request. You have 15 calendar days from the effective date of the leave to submit this Form. You are advised to provide the health care provider a copy of your classification specification (aka job description) with this Form for a leave request for your own serious health condition.

Please type or print legibly.

Employee Name: _________________________________ Classification/Department _____________________________________

Patient's Name (if other than employee): ________________________ Relationship: ___________________ Age if Child: ________

Employee Signature: ____ Date: ___________________________

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE HEALTH CARE PROVIDER ONLY

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Please answer all questions relative to the patient listed above as fully and completely as possible. There are questions that require answers about the frequency or duration of a condition or treatment; 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.

Other than providing medical information to the extent necessary to confirm the validity of a leave request to care for a family member/eligible individual with a serious health condition, we ask that you do not provide any genetic information. "Genetic information" includes family medical history, or any information related to genetic testing, services, or counseling.

Please type or print legibly.

I, ____________________________________, confirm ____ is under my care for an
(Name of Health Care Provider) (Patient's Name)
illness, injury, impairment, or physical or mental condition.

SECTION A: GENERAL INFORMATION

1. Provide the medical facts regarding the health condition which prohibit the patient from working, attending school or performing daily living activities:

2. Provide the approximate date the condition commenced ____________________________and its probable duration ______________________________.

3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes
   a. If yes, denote dates of admission: ____

4. Provide the date(s) you treated the patient for the condition: ____
   ____

5. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

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

7. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ No ☐ Yes
   a. If yes, state the nature of such treatments, expected duration of treatment, and estimated length of time to conduct each appointment/treatment:

8. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, indicate the expected delivery date: ___________________________

9. Indicate the dates the patient is incapable of work, attending school or performing activities of daily living (or for the specified parts of such days):

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

SECTION B: COMPLETE IF THE PATIENT IS THE EMPLOYEE

1. Is the employee able to perform their job functions? ☐ No ☐ Yes

   a. If no, identify the job functions the employee is unable to perform:

2. Will the employee be incapacitated for a single continuous period of time due to their medical condition, including any time for treatment and recovery? ☐ No ☐ Yes

   a. If yes, please indicate the beginning date ______________________ and the estimated end date ________________________.

3. Will the employee need follow-up treatment appointments or need to work part-time or on a reduced schedule due to the medical condition: ☐ No ☐ Yes

   a. If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ No ☐ Yes

      i. If yes, estimate the treatment schedule, including dates of follow-up appointments and time required for each appointment, including any recovery period:

      ii. Also estimate the part-time or reduced work schedule the employee needs:

         a) Hour(s) per day ____;

         b) Days per week ____;

         c) From ___________________________________ through ___________________________________.

4. Will the condition cause episodic flare-ups periodically preventing the employee from performing their job functions? ☐ No ☐ Yes

   a. If yes, is it medically necessary for the employee to be absent from work during the flare-ups? ☐ No ☐ Yes

      i. If yes, explain how/why the employee is prevented from performing their job functions:

      ii. Based on the patient's medical history and condition, estimate the frequency and possible duration of flare-ups within the next six (6) months (e.g., 1 episode every 3 months lasting 1-2 days):

         Frequency: _______________________________________ Duration: ____

5. Provide Any Additional Information if Applicable:

SECTION C: COMPLETE IF THE PATIENT IS THE SPOUSE, SON, DAUGHTER, PARENT OR PARENT-IN-LAW/DOMESTIC PARTNER'S PARENT OF THE EMPLOYEE

1. Will the patient be incapacitated for a single continuous period of time due to their medical condition, including any time for treatment and recovery? ☐ No ☐ Yes
   a. If yes, please indicate the beginning date ____________________ and the estimated end date ______________________.
      i. During this time, will the patient need care? ☐ No ☐ Yes
         a) If yes, explain the care needed by the patient and why such care is medically necessary:

2. Will the patient require follow-up treatment(s), including any time for recovery? ☐ No ☐ Yes
   a. If yes, estimate the treatment schedule, including dates of follow-up appointments and time required for each appointment, including any recovery period:
   b. Also, explain the care needed by the patient, and why such care is medically necessary:

3. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes
   a. If yes, estimate the hours the patient needs care on an intermittent basis:
      i. Hour(s) per day ____;
      ii. Days per week ____;
      iii. From _________________________________ through _________________________________.
   b. If yes, explain the care needed by the patient, and why such care is medically necessary:

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

   ☐ No ☐ Yes

   If yes,
   a. does the patient need care during these flare-ups? ☐ No ☐ Yes
   b. based on the patient's medical history and condition, estimate the frequency and possible duration of flare-ups within the next six (6) months (e.g., 1 episode every 3 months lasting 1-2 days):

      Frequency: _________________________________ Duration: _____________________________________
   c. explain the care needed by the patient, and why such care is medically necessary:

5. Provide any Additional Information if Applicable:

Please type or print legibly:

Name of Health Care Provider: _____________________________________ Type of Practice/ Medical Specialty: _____________________________

Health Care Provider Business Address: ____

Telephone Number: _____________________________________ Fax Number: _______________________________________

Signature of Health Care Provider: ____ Date: ______________________________