WAUKESHA COUNTY

Health Care Provider Certification Form

(Non-FMLA)

HR-1500-I and HR-2600-B

Dept of Administration-Human Resources Division
Waukesha County Administration Center
515 W. Moreland Blvd.
Waukesha, WI 53188
Phone: 262-548-7044
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HR@waukeshacounty.gov

INSTRUCTIONS TO THE EMPLOYEE: Please complete this section before giving this Form to your health care provider. Failure to provide a complete and sufficient Health Care Provider Certification Form may result in a denial of your Non-FMLA Leave request. This Form is to be submitted with the Non-FMLA Leave of Absence Request Form (HR 1500-A). You are advised to provide the health care provider a copy of your classification specification (aka job description) to assist them in providing the appropriate information.

Please type or print legibly.

Check the box indicating the type of leave you are requesting:

- ☐ Use of Paid Benefits (such as sick leave) for my own non-work related health condition for one of the following reasons: (1) not eligible for WI and/or federal FMLA at this time, (2) have exhausted the maximum amount of leave allowed under Wisconsin and/or Federal FMLA for this calendar year, or (3) not instituting my rights under FMLA at this time as permissible by the County.
- ☐ Extended Illness Leave of Absence (I have exhausted all my paid benefits and the maximum amount of leave allowed under Wisconsin and/or Federal FMLA for this calendar year.)
- ☐ WI Bone Marrow and Organ Donation Leave

Employee Name: _____ Classification/Department _____

I authorize my health care provider to release medical information for the purpose of authenticating my leave request.

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.

GINA Notification: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please type or print legibly.

SECTION A: COMPLETE FOR WI BONE MARROW AND ORGAN DONATION LEAVE

I, _____, certify as follows:
(Name of Health Care Provider)

1. _____ has a serious health condition that necessitates a bone marrow or organ transplant.
(Donee's Name)

2. _____ is under my care, is eligible, and has agreed to serve as a bone marrow or
(Employee's Name)
organ donor for _____.
(Donee's Name)

3. _____ will need to be off from work for the bone marrow or organ donation procedure
(Employee's Name)
and to recover from said procedure, as specified, on the following dates: _____.

4. I expect the employee may return to work on (date) _____

SECTION B: COMPLETE FOR NON-WORK RELATED PERSONAL INJURY OR ILLNESS

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

1. Provide the medical facts regarding the health condition which prohibit the patient from working and/or performing daily living activities (e.g., symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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 and/or performing activities of daily living (or for the specified parts of such days):

10. Is the employee able to perform their job functions? ☐ No ☐ Yes
    If no, identify the job functions the employee is unable to perform:

11. 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
    If yes, please indicate the beginning date _____ and the estimated end date _____.

12. 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 _____.

13. Will the condition cause episodic flare-ups periodically preventing the employee from performing their job functions or performing activities of daily living? ☐ 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: _____

14. 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: _____