UNIVERSITY OF WISCONSIN SYSTEM
CERTIFICATION BY HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION
(WISCONSIN FAMILY AND MEDICAL LEAVE ACT ONLY)

This form should be used if an employee is eligible for **Wisconsin FMLA only**. An employee may only be eligible for WI FMLA if the employee does not meet the work requirements of federal FMLA.

SECTION 1: For completion by the EMPLOYER

Name of UW Institution:

Name of Employer Contact:

Address of Employer:

Employer Contact Phone: | Fax:

Employer Contact Email:

SECTION 2: For completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section 2 before giving this form to your medical provider. If requested by your employer, your response is required to obtain or retain the benefit of WFMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your WFMLA request.

Name of Employee (Patient):

SECTION 3: For completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed in Section 2 has requested leave under the Wisconsin FMLA. Please answer all questions relative to the patient listed in Section 2 as fully and completely as possible. Please sign the second page of the form.

1. Does the patient have a serious health condition?

☐ Yes (go to #2) ☐ No (provide signature and return to employer listed in Section 1)

* 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.

2. Approximate begin date of condition:

3. Probable duration of condition:

4. Describe the medical facts regarding the serious health condition (e.g. symptoms, diagnosis, continuing treatment):

5. Indicate the extent to which the employee is unable to perform his or her employment duties:	
6. The patient was seen by me and treated for this serious health condition on the following dates:	
Name of Health Care Provider:	
Business Address:	
Telephone Number:	Fax:
Type of Practice/Medical Specialty:	
Signature of Health Care Provider: _____ Date: _____	
Note To Health Care Provider: Please return this completed form to either the employee listed in Section 2 or to the Employer Contact listed in Section 1. Thank you.	

Genetic Information Nondiscrimination Act of 2008 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 including, but not limited, to when the employee requests leave for a family member's health condition to (1) document appropriate use of sick leave; and (2) where "family medical history" is required to the extent necessary to make the medical certification complete and sufficient under the FMLA and WFMLA.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information unless it meets the family member exceptions noted above.

'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or 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.