CITY OF WAUPACA

FAMILY AND MEDICAL LEAVE ACT
CERTIFICATION OF PHYSICIAN OR PRACTITIONER

1. Employee's Name: _____

2. Patient's Name: _____
(If other than employee)

3. Diagnosis: _____

_____

4. Date condition commenced: _____

5. Probable duration of condition: _____

6. Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week):

   a. By Physician or Practitioner: _____

   _____

   _____

   _____

   b. By another provider or health services, if referred by Physician or Practitioner:

   _____

   _____

   _____

   _____

IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEM NOS. 7 - 9 AND PROCEED TO ITEM NOS. 10 - 14.

Check Yes or No in the parenthesis below, as appropriate.

	Yes	**No**	
7.	( )	( )	Is inpatient hospitalization of the employee required?
8.	( )	( )	Is employee able to perform work of any kind? (If no, skip to Item No. 9)
9.	( )	( )	Is employee able to perform the function of employee's posting? (Answer after reviewing statement from employee of essential functions of employee's position, or, if none provided, after discussing with employee.)

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEM NOS. 10 - 14 BELOW AS THEY APPLY TO THE FAMILY MEMBER AND PROCEED TO ITEM NO. 15.

Check Yes or No in the parenthesis below, as appropriate.

	Yes	No	
10.	( )	( )	Is inpatient hospitalization of the family member (patient) required?
11.	( )	( )	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?
12.	( )	( )	After review of the employee's signed statement (See Item No. 14 below) is the employee's presence necessary or will it be beneficial for the care of the patient? (This may include psychological comfort.)

13. Estimate the period of time care is needed or the employee's presence would be beneficial: _____

ITEM NO. 14 TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE

14. When Family Leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule

15. _____ _____
Signature of Physician or Practitioner Type of Practice (Field of Specialization, if any)

16. _____
Date

I understand that any misrepresentation by me in completing this form may subject me to disciplinary action by the Employer. I attest to the truthfulness and accuracy of the above information.

_____ _____
Employee Signature Date

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