



HUMAN RESOURCES DEPARTMENT

127 East Oak Street, Juneau, WI53039 • 920-386-3690 • Fax 920-386-3545

MEDICAL CERTIFICATION - SPOUSE / CHILD / PARENT

Name of Patient: _____ Relationship to Employee: _____

Name of Dodge County Employee: _____

****BIRTH OF A CHILD ONLY**:** The birth is expected, on or about _____

Skip to bottom of form and complete Name, Address, Date and Sign

To the Health Care Provider: To determine whether the request meets the requirements of a "Serious Health Condition" under the family leave laws, please review the following and provide the requested information, as appropriate. THANK YOU!

Wisconsin State Statute, 103.10 (1)(g) defines "Serious Health Condition" as, a disabling physical or mental illness, injury, impairment or condition involving inpatient care in a hospital, nursing home, or hospice, and outpatient care that requires continuing treatment or supervision by a health care provider.

Federal Family Medical Leave Act of 1993, 29 CFR Part 825, 114 defines a "Serious Health Condition" as an illness, injury, impairment, or physical or mental condition that involves:

- Any period of incapacity or treatment connected with inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility; or
- A period of incapacity requiring absence of more than three (3) calendar days from work, school, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a health care provider; or
- Any period of incapacity due to pregnancy, or for prenatal care; or
- Any period of incapacity (or treatment therefore) due to a chronic serious health condition (i.e. asthma, diabetes, epilepsy, etc.); or
- A period of incapacity that is permanent or long-term due to a condition for which may not be effective (i.e. Alzheimer's, stroke, terminal diseases, etc.); or
- Any absence to receive multiple treatments (including any period of recovery therefrom) by, or referral by, a health care provider for a condition that likely would result in incapacity of more than three (3) consecutive days if left untreated (i.e. chemotherapy, physical therapy, dialysis, etc.).

Health Care provider, please read the following and check the boxes as appropriate.

- The above named individual HAS a **serious health condition** as define above.
- The above named individual DOES NOT have a **serious health condition** as defined above.

Accordingly, I certify that:

The serious health condition commenced on _____ and has a probable duration through _____

Continuous Leave: *The serious health condition is such that the patient needs the employee to care for him/her. A serious health condition is any condition that affects the individual's ability to engage in normal daily activities.*

Employee will be needed to remain off of work to care for the spouse, child, or parent for approximately:

From: _____ Through: _____ (cannot be "unknown", or "TBD")

Intermittent Leave/Reduced Hours Leave: *Based on patient medical history and knowledge of medical condition please estimate treatment schedule and/or frequency of intermittent leave:*

From: _____ Through: _____ (cannot be "unknown", or "TBD")

_____ hours/day for _____ days/week OR

_____ hours/day for _____ days/month OR

Other: _____ (must specify; cannot be "as needed" or "TBD")

Signature of Health Care Provider

Name of Health Care Provider (Please Print)

Address/City/State/Zip code

Date

Telephone Number