Certification of Health Care Provider
for Employee's Serious Health Condition (Medical Leave)
Family and Medical Leave Act

MARQUETTE UNIVERSITY
HUMAN RESOURCES

SECTION I: For Completion by the EMPLOYER

Employer name and contact: Marquette University, Human Resources
915 W. Wisconsin Ave., Room 185, Milwaukee, WI 53233
Phone: (414) 288-7305 | Fax: (414) 288-7425 | benefits@marquette.edu

GINA Notification to Employee and Health Care Providers: 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 for medical information. `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.

SECTION II: For Completion by the EMPLOYEE

Please complete Section II before giving this form to your medical provider. The FMLA permits the employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **You must return this form to Human Resources within 15 calendar days of the date you received it.**

Employee's name: _____ Employee's Job Title: _____

Employee's essential job functions: _____

☐ Job description is attached

SECTION III: For Completion by the HEALTH CARE PROVIDER

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. ***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.*** Limit your responses to the condition for which the patient is seeking leave—see GINA notification above. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page. **The employee must return this form to Human Resources within 15 calendar days of the date she/he received it.**

Provider's name: _____

Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   a. Probable duration of condition: _____

   b. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

      ___ No ___Yes. **If Yes**, dates of admission: _____

   c. Please list the date(s) you treated the patient for condition: _____

   d. Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

   e. Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___Yes

   f. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)?

      ___ No ___Yes. **If Yes**, state the nature of such treatments and expected duration of treatment:

      _____

      _____

2. Is the medical condition pregnancy? ___No ___Yes. **If Yes**, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ___No ___Yes

   If Yes, identify the job functions the employee is unable to perform: _____

   _____

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

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED:

1. **Will the employee be incapacitated** for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes. **If Yes**, **estimate the beginning and ending dates** for the period of incapacity: _____

2. **Will the employee need to attend follow-up treatment appointments, or work part-time** or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If Yes, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes

   Estimate the part-time or the reduced work schedule the employee needs, if any:

   #____ hours per day; #____ days per week from _____ (date) to _____ (date).

   Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:_____

   _____

   _____

3. Will the condition cause **episodic flare-ups,** periodically preventing the employee from performing his/her job functions? ___No ___Yes.

   a. **If Yes,** is it medically necessary for him/her to be absent from work during the flare-ups? ___No ___Yes

      Explain how/why the employee is prevented from performing his/her job functions:_____

      _____

   b. **If yes**, based upon the patient's medical history and your knowledge of the medical condition**, estimate the frequency of flare-ups** and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

      Frequency: #____ times per ____ week(s) /month(s) (circle one)

      Duration per episode: #____hours, **or** #____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Be sure to sign on the bottom of the page.

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider Date