Certification of Health Care Provider
for Family Member's Serious Health Condition (Caretaker 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 family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a 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: _____
First Middle Last

Name of family member for whom you will provide care:

_____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, family member's date of birth: _____

Describe care you will provide to your family member and estimate the amount of leave needed to provide care:

_____

_____

_____

_____

_____ _____
Employee Signature Date

SECTION III: For Completion by the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. 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 needs care — see GINA notification on Page 1. 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. **Describe other relevant medical facts, if any, related to the condition for which the patient needs care:** (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment)

_____

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

1. **Will the patient be incapacitated** for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes. **If Yes**, **estimate the beginning and ending dates** for the period of incapacity:

   _____

   During this time, **will the patient need care?** ___No ___Yes. **If Yes, explain the care needed** by the patient and why such care is medically necessary: _____

   _____

2. **Will the patient require follow-up treatment appointments**, including any time for recovery? ___No ___Yes.

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

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

3. **Will the patient require care on an intermittent or reduced schedule basis**, including any time for recovery?

   ___No ___Yes. **If Yes**, estimate the hours the patient needs care on an intermittent basis, if any:

   #_____ hour(s) per day; #_____ days per week, from _____ (date) through _____ (date)

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

4. Will the condition cause **episodic flare-ups,** periodically preventing the patient from participating in normal daily activities? ___No ___Yes.

   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):

   a. Frequency: #_____ times per _____ week(s) /month(s) (circle one)

   b. Duration per episode: #_____hours, **or** #_____ day(s) per episode

   c. Does the patient need care during these flare-ups? ___No ___Yes.

      If Yes, explain the care needed by the patient, and why such care is medically necessary:_____

      _____

If you wish to provide additional information please use the reverse side. Identify question number with your additional answer. Be sure to sign below.

_____ _____

Signature of Health Care Provider Date