Spooner Area School District

FMLA CERTIFICATION OF HEALTH CARE PROVIDER

THIS CERTIFICATION MUST BE COMPLETED AND RETURNED WITHIN 15 CALENDAR DAYS. FAILURE TO PROVIDE A COMPLETED CERTIFICATION ON A TIMELY BASIS MAY RESULT IN THE DELAY OR DENIAL OF FMLA LEAVE

Section I: To Be Completed by the Employer

Employer: Spooner Area School District, 801 Cty Hwy A.,Spooner, WI 54801

District Contact: Katelyn Riewestahl Human Resources 715-635-2171 x4001

Employee Name: _____ Location of Responsibilities (School): _____

Employee's Essential Job Functions: _____

_____

Section II: To Be Completed by the Employee ONLY if Leave Request is for a Family Member

Name of patient for whom you will provide care: _____

Relationship to you: _____

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

Describe the care you will provide to your family member and the estimated amount of leave needed to provide such care *(Verification form required for Domestic Partner)*:

_____

_____

_____ _____

Employee Signature Date

Section III: To Be Completed by the Health Care Provider

Provider Name and Address *(Please Print)*: _____

_____

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

Type of Practice/Medical Specialty: _____

MEDICAL FACTS:

1. Approximate date condition commenced: _____

2. Probable duration of condition: _____

   a. Was the patient admitted for an overnight stay in a hospital, hospice, or residential care facility? Yes No

      If yes, please list dates of admission: _____

   b. Please list the date(s) patient was treated for this condition: _____

   c. Was medication, other than over-the-counter, prescribed? Yes No

   d. Will the patient need to have treatment visits at least twice per year due to the condition? Yes No

   e. Was the patient referred to another provider for evaluation or treatment (e.g. physical therapist)? Yes No

      If yes, state the nature of such treatments and expected duration of treatment: _____

   f. Is the medical condition pregnancy? Yes No

      If yes, expected delivery date: _____

3. Please provide any other relevant medical facts as they relate to this condition (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment): _____

_____

_____

_____

4. When patient is District employee: After reading the job functions in Section I or speaking with the patient regarding his/her duties, is the patient unable to perform any of his/her job functions due to the condition: Yes No

If yes, please list restrictions or limitations to his/her job functions: _____

_____

_____

AMOUNT OF LEAVE OR AMOUNT OF CARE NEEDED:

5. Will the patient be incapacitated for a single, continuous period of time, including any time for treatment and recovery? Yes No

a. If yes, pleased provide dates of incapacity: _____

b. During this time will the patient need care? Yes No

c. Please explain: _____

_____

_____

d. Will the patient require follow-up treatments? Yes No

If yes, please provide estimated treatment schedule: _____

6. Please explain the care needed by the patient and why such care is medically necessary: _____

_____

7. If the patient is a District employee, will the patient require intermittent or reduced schedule work? Yes No

If yes, please explain, including the hours patient will need care intermittently: _____

_____

_____

a. Estimated patient's part-time or reduced-work schedule: _____

_____Hrs per day _____Days per Week From_____ through _____

b. Will the condition cause episodic flare-ups preventing the patient from performing his/her job functions? Yes No

(i) If yes, is it medically necessary for the patient to be absent from work during the flare-ups? Yes No

(ii) Estimated frequency and duration of flare-ups: _____

_____

8. Does the patient require care during these flare-ups? Yes No

Please explain the required patient care and why such care is medically necessary: _____

_____

_____

_____

_____

_____

Spooner Area School District

9. Is an attendance record attached to this certification? Yes No

a. If yes, did you review it? Yes No

b. If yes, is the serious health condition and need for leave consistent with such a pattern of absences?

Yes No

c. Please explain your answer: _____

_____

_____

ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider Date

_____

Location of Health Care Provider

_____

Contact Information