JEFFERSON SCHOOL DISTRICT
FAMILY AND MEDICAL LEAVE REQUEST
HEALTH CARE PROVIDER CERTIFICATION

NOTE TO HEALTH CARE PROVIDER: Please avoid use of the terms "lifetime," "unknown," or "indeterminate," when responding to questions relating to the frequency or duration of a condition or its treatment. Such terms may not be sufficient to determine FMLA coverage.

Employee Requesting Leave: ____

I, ______________________________________, confirm that ____
(Name of Health Care Provider or Christian Science Practitioner) (Patient's Name)

is under my care for an illness or injury, impairment or physical or mental condition involving (check the appropriate box):

- □ Inpatient care in a hospital, hospice or residential medical facility; and/or
- □ Any period of absence which:
  - renders the person incapable of performing work, school attendance, or other regular activities; and
  - involves continuing treatment or supervision by a health care provider;
- □ Continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that it may result in a period of incapacity;
- □ Any period of absence which renders a service person who is a family member unable to perform the duties of his/her rank;
- □ A period of absence during which a covered veteran service member who is a family member is undergoing medical treatment, recuperation or therapy for a qualifying serious illness or injury;
- □ Prenatal care; or
- □ None of the above.

In addition, my understanding is that the patient is one of the following (check the appropriate box):

- □ An employee of the District;
- □ The spouse of an employee;
- □ The son or daughter of an employee;
- □ The domestic partner of an employee;
- □ A covered service member who has incurred or aggravated a serious illness or injury in the line of duty and is the son, daughter, spouse or next of kin of the employee;
- □ The parent (including a parent in law and parent of domestic partner) of an employee; or
- □ None of the above.

Accordingly, I confirm that:

1. My area of medical practice is: ____.
2. The health condition commenced on __________, 20_____ and has a probable duration through ________________, 20_____.

3. The patient was first seen by me relative to, and treated for, this health condition on ____________. In addition, I have provided care to the patient on the following date(s) (list all dates of treatment or supervision):

____

____

4. The patient's condition has manifested itself for the dates of absence in question in the following manner (specifically describe including impact on ability to work, attend school or perform activities of daily living):

____

____

5. If the individual is a service member who has incurred a serious illness or injury in the line of duty, please specify how the patient's condition has manifested itself (specifically describe impact on ability to perform the duties of his/her rank):

____

____

Please describe the origin of the service member's illness or injury:

____

____

6. I will be providing care to the patient on the following dates (list all dates of treatment or supervision):

____

____

7. The patient was treated on an ☐ inpatient ☐ outpatient basis (check as applicable).

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

If Yes, please describe impact on patient:

____

____

9. Describe other relevant medical facts, including symptoms, diagnosis, or any regimen of continuing treatment.

____

____

10. Was the procedure/treatment scheduled in advance or on an emergency basis? If scheduled in advance, please indicate how many days in advance the treatment was scheduled.

    Scheduled in advance ☐ Emergency Basis ☐

    Date scheduled: ______________________________

    Comments, if any: ______________________________

<u>If the patient is an employee</u>: the health condition must render the employee unable to perform the functions of his or her position which means the employee is unable to work at all or is unable to perform the essential functions of the position.

1. Is the employee able to perform the following employment functions during the period over which the absence from work occurred/is occurring:

Yes	No	
☐	☐	Standing for 30 minutes or less
☐	☐	Standing for more than 30 minutes but less than 2 hours (with or without breaks)
☐	☐	Standing for more than 2 hours (with or without breaks)
☐	☐	Sitting for 30 minutes or less
☐	☐	Sitting (with or without breaks) for more than 30 minutes but less than 2 hours
☐	☐	Sitting (with or without breaks) of 2 hours or more
☐	☐	Walking short distances (20 yards)
☐	☐	Arm movement (if limited please note below)
☐	☐	Lifting less than 20 pounds
☐	☐	Lifting 20 or more pounds
☐	☐	Speaking

2. Is the employee limited to working 40 or fewer hours per week (exclusive of breaks and other time off of active work?)

    ☐ Yes ☐ No

3. If the employee requires intermittent (leave taken in separate blocks of time) or reduced leave (leave that reduces the employee's hours per workweek or workday) which is medically necessary, please describe why the intermittent or reduced leave is medically necessary.

    ____

    ____

    ____

    Please identify the dates on which treatment/care is to be provided: ______________

    How long will the employee need to be absent for each appointment? ______________

    ____

<u>If the patient is the spouse, domestic partner, son, daughter or parent of the employee</u>: the health condition of such individual must require that the employee is needed to care for such individual. A health condition for such individual must be such that affects an individual's ability to engage in normal daily activities.

1. The employee will be needed to care for the spouse, parent, domestic partner, son or daughter on the following dates:

   ____

   (Please indicate which portion of such days will be required for care, i.e., hours needed for care):

   ____

2. What is the date of birth of the child? ______________________

3. Is the patient incapable of performing certain activities of daily living without assistance from the employee? If so, please indicate which of the following may not be performed by the patient because of the patient's condition (check as appropriate):

   □ Personal grooming □ Personal hygiene
   □ Bathing □ Dressing
   □ Eating □ Cooking & cleaning
   □ Shopping □ Using a telephone
   □ Other (please specify) ______________________

4. Describe care to be provided by the employee:______________________

   ____

5. If the employee requires intermittent (leave taken in blocks of time) or reduced leave (leave that reduces the employee's hours per workweek or workday) to care for the employee's spouse, domestic partner, parent, son or daughter, please describe why it is medically necessary:

   ____

   ____

   ____

   Please identify the treatment schedule (dates and times): ______________________

   ____

Dated this ______________________ day of ______________, 20___.

______________________________ ______________________
Signature of Health Care Provider/ Telephone Number
Christian Science Practitioner

______________________________ ______________________
Address City/State

Important Note: Certain states have enacted anti-fraud provisions making it a crime to provide false information to obtain for oneself or another employee benefit from an employer. Specifically, Wis. Stat. Section 943.395 prohibits anyone from knowingly providing false or fraudulent information in the presentation of a claim, or any proof in support of such claim to be paid under any contract or certificate of insurance; or prepares, makes or subscribes to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing with knowledge that the same may be represented or used in support of a claim for payment under a policy of insurance; or presents or causes to be presented a false or fraudulent claim or benefit application or any false or fraudulent proof in support of such a claim or benefit application or false or fraudulent information which would affect a future claim or benefit application to be paid under any employee benefit program created by Chapter 40; or makes any misrepresentation in or with reference to any application for membership or documentary or other proof for the purpose of obtaining membership or in or noninsurance from any fraternal subject to Chapter 600-646 from himself, or herself or any other person.

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

____
Name of Patient/Previous Name

DISCLOSURE OF HEALTH INFORMATION TO:

Jefferson School District
206 S. Taft Avenue
Jefferson, WI 53549-1453

PATIENT AUTHORIZES DISCLOSURES BY:

____
Name of Treating Health Care Provider

____
Phone Number and Fax Number of Treating Health Care Provider

INFORMATION TO BE DISCLOSED: ***Check all of the following that apply:***

Medical Records: _X_ Treatment Records: _X_ Diagnostic Records: _X_ Other: Phone contact and other medical information as requested.

DISCLOSURES REQUIRING SPECIAL CONSENT: *In compliance with State and Federal Statues which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed.* ***Check all that apply****:*

_____ HIV/AIDS ____Mental/Behavioral Health Conditions _____ Drug/Alcohol Abuse Treatment

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

_____ Disability Determination _____ Workers Compensation
_____ Continued Medical Leave _____ Other – Employment Related Evaluation/Leave Request

I hereby authorize my current physician(s) or medically related facilities to release any records, knowledge or information concerning any evaluation or treatment provided to me regarding my current medical condition since my employment with the Jefferson School District for up to five (5) years ago.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I have a right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form. I understand that if I agree to sign this authorization, I must be provided with a copy. I understand that I am under no obligation to sign this form. I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

_________________________________ _________________________________
Signature of Patient Date

Expiration Date: This authorization will expire within **90 days** of the date of my signature or on the following date or event (please specify): ____

COMPANY: Jefferson School District, 206 S. Taft Avenue, Jefferson, WI 53549-1453

5/24/10