

FAMILY AND MEDICAL LEAVE

HEALTH CARE PROVIDER CERTIFICATION

Employee requesting leave: _____ Date: _____

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;
☐ Prenatal care; or
☐ None of the above – please describe _____

In addition, it is my understanding that the patient is (check the appropriate box):

- ☐ An employee of the City of Appleton
☐ The spouse of an employee;
☐ The son or daughter of an employee;
☐ The parent of an employee; or
☐ None of the above – please describe other relationship _____

Accordingly, I confirm that:

- 1. My area of medical practice is: _____
2. The health condition commenced on _____ and has the probable duration through _____.
3. The patient was/is being treated on an ___inpatient ___outpatient basis. Did you or will you see the patient two or more times? Please list dates _____
4. The medical facts regarding the health condition are as follows, including the treatment employed for the condition. (If outpatient, please state whether there was a regimen or continuing treatment involving medication and/or treatment. If so, please describe the medication and/or treatment plan and for what period of time said treatment is/was required): _____
5. 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: _____

If the patient is an employee: 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.

- Please list the functions that the employee is able to perform in the chart below:

N=Never/Not Able		F=Frequent up to 30x/hr.				
O=Occasional up to 4 times/hr.		C=Constant over 30x/hr.				
Specify Restrictions for 24 day						
	N	O	F	C		
Sitting/Driving					Lab Work	Yes ___ No ___
Standing/Walking						
Climbing					X - Rays	Yes ___ No ___
Bending						
Kneeling/Squatting/Crawling						
					R	L Bil.
Reaching-Horiz./push-pull						
Reaching-Vert./above shoulder						
Gross Handling						
Finger Manipulation						
Single Grasping						
Repetitive Foot Movement						

- Is the employee limited in the number of hours per day he/she may work? ___yes ___no If yes, please describe the limitation_____.
- Is an intermittent or reduced leave schedule needed? If yes, please describe:_____

If the patient is the spouse, son, daughter or parent of the employee: the health condition of such individual must require that the employee is need to care for such individual. A health condition for such individual must be such that it affects an individual’s ability to engage in normal daily activities.

- The employee will be needed to care for the spouse, parent, son or daughter on the following dates:_____
- Is the patient incapable of performing certain activities of daily living without assistance from the employee? If no, please list the activities._____
- Describe the care to be provided by the employee _____
- Is an intermittent or reduced work schedule needed? If yes, please describe_____

Dated this _____ day of _____, 20__

Signature of Health Care Provider/
Christian Science Practitioner

Telephone number

Address

City/State

Medical Authorization Release

I, _____, hereby authorize the above-reference health care provider, or others to which I am directed to for care relative to the health condition set forth above, to confer with medical representatives of the City of Appleton to clarify or supplement any information set forth herein without liability. I also authorize the use or disclosure of my health information (which may also be referenced as protected health information "PHI") as described in this authorization. I also agree to provide such further authorizations as the Company may request to process and classify my requested time off for FMLA purposes.

HIPAA Authorization

I understand that I have the right to revoke this authorization at any time by notifying my supervisor or the Human Resources Department. I also understand that the revocation will only become effective after it is received and recorded by the City of Appleton. I understand that any use or disclosure made prior to the time that such revocation becomes effective will not be affected by that revocation. If I do not revoke this authorization, it will expire at the end of my FMLA leave or shortly thereafter if additional time is needed to process documentation related to my leave (for example, verification of fitness for duty). If the City of Appleton's representatives require additional information related to my health condition after my leave request and all related documentation is completed, they must request that new authorization be signed by me.

I understand that I am entitled to receive a copy of this authorization form and acknowledge receipt of one.

Dated this ____ day of _____, 20__

Signature
(print name): _____