



FEDERAL AND WISCONSIN FAMILY AND MEDICAL LEAVE

FORMS PACKET

Office of Employee Services

TABLE OF CONTENTS

NOTE TO EMPLOYEE CONSIDERING FAMILY AND/OR MEDICAL LEAVE3

FMLA – RELATED FORMS4

 Employee Leave Request Form5

 Physician Certification of Short-Term Illness (for Illness Exceeding Three Consecutive
 Days but Not Expected to Exceed Ten (10) Days)6

 Physician Certification for Employee’s Serious Illness7

 Physician Certification for Family Member’s Serious Illness11

 Physician’s Release to Work Following Employee’s Serious Illness/Injury15

MILITARY FMLA FORMS17

 Certification of Qualifying Exigency for Military Family Leave18

 Certification of Serious Illness or Injury of a Covered Service Member for Military Family Leave21

NOTE TO EMPLOYEE CONSIDERING FAMILY AND/OR MEDICAL LEAVE

This is a supplement to the "Federal and Wisconsin Family and Medical Leave Laws – Employee Guide and Notice of Rights. Please review the Guide and Notice of Rights before completing the forms contained in this booklet.

Forms required for ALL FMLA requests:

- **Employee Leave Request Form**
- **Physician's Release to Work Following Employee's Serious Illness/Injury** – completed by physician to release employee back to employment with no restrictions or with recommendations for limitations

Forms required, based on circumstance of leave:**MEDICAL NEED**

- Physician's Certification of Short-Term Illness (For Illness Exceeding Three Consecutive Days but Not Expected to Exceed 10 days) – completed by attending physician
- Physician's Certification of Employee's Serious Illness – completed by both employee and attending physician
- Physician's Certification of Family Member's Serious Illness – completed by both employee and family member's attending physician

MILITARY NEED

- Certification of Qualifying Exigency for Military Family Leave – completed by employee
- Certification of Serious Illness or Injury of a Covered Service Member for Military Family Leave – Completed by both the employee and/or covered service member and by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider

FMLA – RELATED FORMS

**NOTE: PLEASE REVIEW THE FEDERAL AND WISCONSIN FAMILY AND MEDICAL LEAVE LAWS -
EMPLOYEE'S GUIDE AND NOTICE OF RIGHTS**



Challenge ★ Inspire ★ Support
**MIDDLETON-CROSS PLAINS AREA SCHOOL DISTRICT
PHYSICIAN'S CERTIFICATION OF EMPLOYEE OR FAMILY MEMBER'S ILLNESS
GREATER THAN THREE (3) CONSECUTIVE DAYS**

Employee Name: _____

I, _____, certify that _____ has a
(Name of Health Care Provider) (Patient's Name)

condition or illness involving:

any period of incapacity requiring absence from work, school, or other regular activities of more than three (3) calendar days but not expected to exceed ten (10) days that involves continuing treatment or supervision by a health care provider;

In addition, I certify that the patient is one of the following (Check the appropriate box):

- An employee of the Middleton-Cross Plains Area School District;
- The spouse of an employee of the Middleton-Cross Plains Area School District;
- The son or daughter of an employee of the District; or
- The parent of an employee of the Middleton-Cross Plains Area School District.

Accordingly, I certify that:

The serious health condition commenced on _____, 20____, and has a probable duration through _____, 20____.

The patient was assessed and was recommended to NOT be in attendance at work until his/her symptoms subside.

The patient was treated on an inpatient outpatient basis (check which is applicable).

The medical facts regarding the health condition are as follows:

If the patient is the spouse, son, daughter or parent of the employee: the serious health condition of such individual must require that the employee is needed to care for such individual. A serious health condition for such individual is a condition which makes the individual unable to engage in normal daily activities.

The employee will be needed to care for the spouse, parent, son or daughter for approximately the following length of time:

Describe care to be provided by employee: _____

Dated this _____ day of _____, 20____.

Signature of Health Care Provider/

Telephone Number

Address

City/State



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

Employer name and contact: Middleton-Cross Plains School District; Lori Krug-Benefits Specialist (608) 829-9044

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. **Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).**

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

ATTENTION HEALTH CARE PROVIDER
Please return this form by fax to:
Benefits Specialist; 608-836-3571



PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

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

No Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

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

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

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

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

2. Is the medical condition pregnancy? No Yes. If so, 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 so, 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 as 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

5. 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 so, estimate the beginning and ending dates for the period of incapacity: Begins _____
Ends _____

6. 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 so, are the treatments or the reduced number of hours of work medically necessary? No Yes.

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

Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day;
_____ days per week from _____ through _____.

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

Is it medically necessary for the employee to be absent from work during the flare-ups? No Yes.
If so, explain: _____

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) _____

Duration: _____ hours or _____ day(s) per episode



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

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II and the Employee Name and Patient Name in Section III 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. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. ***You must return this form within 15 calendar days to the contact listed above.***

Your 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, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care: _____

Employee Signature _____

Date _____ Print Name _____



SECTION III: For Completion by the HEALTH CARE PROVIDER

RE: _____
Employee Name

Patient's Name _____

INSTRUCTIONS to 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 leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

1. Approximate date condition commenced: _____

Probable duration of condition: _____

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

Yes No.

PART A: MEDICAL FACTS

If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? Yes No. Will the patient need to have treatment visits at least twice per year due to the condition? Yes No.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes No

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

2. Is the medical condition pregnancy? Yes No. If so, 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:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?
 Yes No. Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? Yes No. Explain the care needed by the patient and why such care is medically necessary: _____

5. Will the patient require follow-up treatments, including any time for recovery? Yes No.
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: _____

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

Yes No. Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____.

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



7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? Yes No.

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)

Duration: _____ hours or _____ day(s) per episode Does the patient need care during these flare-ups? Yes No.

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Print Name of Health Care Provider here: _____

Signature of Health Care Provider _____

Date _____

ATTENTION HEALTH CARE PROVIDER:
Please return this form by fax to:
Benefits Specialist
608-836-3571



Challenge ★ Inspire ★ Support

**MIDDLETON-CROSS PLAINS AREA SCHOOL DISTRICT
FITNESS TO RETURN TO WORK FORM**

1. Patient's name: _____

2. Date on which patient may resume work: _____

3. The patient is:

Fully Capable or **Limited** in performing.

Explain limitations imposed: _____

Signature of Physician or Practitioner

Type of Practice or Field of Specialty

Printed name of Physician or Practitioner

Date

Attention Attending Physician:
Please return this form to the attention of
Benefits Specialist
Fax: 608-836-3571

MILITARY FMLA FORMS



2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave.
- Such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs.
- Available written documentation supporting this request for leave is attached. Yes No None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____
Probable duration of exigency: _____
2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?
 Yes No

If so, estimate the beginning and ending dates for the period of absence:

_____.

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes No.

Estimate schedule of leave, including the dates of any scheduled meetings or appointments: _____

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours _____ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

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

Email: _____



Describe nature of meeting: _____

PART D: CERTIFICATION BY EMPLOYEE

I certify that the information I provided above is true and correct.

Signature of Employee _____ Date _____



Certification for Serious Injury or Illness of a Covered Service Member for Military Family Leave (Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or COVERED SERVICE MEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered service member. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered service member's serious injury or illness includes written documentation confirming that the covered service member's injury or illness was incurred in the line of duty on active duty and that the covered service member is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. 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 employee is seeking leave.



SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER for whom the Employee Is Requesting Leave:

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer

Middleton-Cross Plains Area School District; 7106 South Avenue, Middleton, WI 53562
(this is the employer of the employee requesting leave to care for covered service member):

Name of Employee Requesting Leave to Care for Covered Service member:

First Middle Last

Name of Covered Service member (for whom employee is requesting leave to care):

First Middle Last

Relationship of Employee to Covered Service member Requesting Leave to Care:

Spouse Parent Son Daughter Next of Kin

Part B: COVERED SERVICE MEMBER INFORMATION

(1) Is the Covered Service member a Current Member of the Regular Armed Forces, the National Guard or Reserves?

Yes No

If yes, please provide the covered service member's military branch, rank and unit currently assigned to:

Is the covered service member assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? Yes No

(2) Is the Covered Service member on the Temporary Disability Retired List (TDRL)? Yes No

If yes, please provide the name of the medical treatment facility or unit: _____

Please route this form back to:

Attention: Benefits Specialist/DAC
or fax to 608-836-3571



Part C: CARE TO BE PROVIDED TO THE COVERED SERVICE MEMBER

Describe the Care to Be Provided to the Covered Service member and an Estimate of the Leave Needed to Provide the Care:

SECTION II: For Completion by a United States Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider’s Name and Business Address:

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

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

PART B: MEDICAL STATUS

(1) Covered Service member’s medical condition is classified as (Check One of the Appropriate Boxes):

- (VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- (SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
- OTHER Ill/Injured** – a serious injury or illness that may render the service member medically unfit to perform the duties of the member’s office, grade, rank, or rating.
- NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a “serious health condition” under § 825.113 of the FMLA. If such leave is requested, you may be required to complete an employer-provided form.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? Yes No

(3) Approximate date condition commenced: _____



(4) Probable duration of condition and/or need for care: _____

(5) Is the covered service member undergoing medical treatment, recuperation, or therapy? Yes No.

If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICE MEMBER’S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered service member need care for a single continuous period of time, including any time for treatment and recovery? Yes No

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the covered service member require periodic follow-up treatment appointments? Yes No

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered service member to have periodic care for these follow-up treatment appointments? Yes No

(4) Is there a medical necessity for the covered service member to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes No

If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider

Date

Please *print* name of Health Care Provider above

Attention Health Care Provider:

Please route this form back to:

Attention: Benefits Specialist/DAC
or fax to 608-836-3571

