State of Wisconsin
Department of Workforce Development
Equal Rights Division

Physician or Practitioner Certification For Family or Medical Leave

Personal information you provide may be used for secondary purposes. See Sec. 15.04 (1) (m), Wis. Stats., for details.

Dear Physician or Practitioner:

To assist in establishing leave entitlements under the Wisconsin Family and Medical Leave Act (Section 103.10, Wisconsin Statutes) please answer the questions checked below and return this certification form to the employer listed below.

Employer Information

Employer Name			
Street Address	City	State	Zip Code

Employee/Patient Name

Employee Name	Patient Name (if not employee)

Information Requested (Employer, please check the appropriate box (es) below identifying the information you need from the physician or practitioner.)

☐ Does _____ have a serious health condition? ☐ Yes ☐ No
(patient name)

Note: The Wisconsin Family and Medical Leave Act (Section 103.10, Wisconsin Statutes) defines a **serious health condition** as a disabling physical or mental illness, injury, impairment or condition involving either inpatient care in a hospital, or outpatient care that requires continuing treatment or supervision by a health care provider.

☐ What date did the condition begin?

☐ What is the probable duration of the condition?

☐ Briefly describe the serious health condition (an exact diagnosis is not required).

_____

_____

_____

_____

☐ Please indicate the extent to which the employee is unable to perform his or her employment duties.

_____

_____

Physician/Practitioner Information

Physician/Practitioner Name (Please Print)	
Signature of Physician/Practitioner	Date Signed

Note to Employer: this information should be retained in a confidential medical file.