IOWA COUNTY
STATE FAMILY AND MEDICAL LEAVE REQUEST
HEALTH CARE PROVIDER CERTIFICATION

Employee's Name: _____

Patient's Name (if other than employee): _____

My patient is one of the following (Check the appropriate box):
[ ] An employee of Iowa County;
[ ] The spouse of an employee of Iowa County;
[ ] The son or daughter of an employee of Iowa County;
[ ] The parent of an employee of Iowa County. (See reverse page for definition of parent.)

1. The serious health condition commenced on _____ and has a probable duration through _____

Employee Signature: I understand that any misrepresentation by me in completing this form may subject me to disciplinary action by the Employer. I attest to the truthfulness and accuracy of the above information.

_____ _____
Employee Signature Date

TO BE COMPLETED BY HEALTH CARE PROVIDER

1. Name of the Health Care Provider (Print): _____
2. Specialty of Health Care Provider:_____
3. Date of Examination(s): _____
4. Describe medical condition of Employee, or Employee's family member: _____

   _____

   _____
5. Was the medical condition described above in item 4: (Check one)

   a. [ ] A serious health condition rendering the person unable to work

   b. [ ] A non-serious health condition rendering the person unable to work

   c. [ ] Unknown
6. If a "serious health condition" the condition commence on _____ and has a probable duration through _____.
7. Employee or ill family member was examined and treated:
   [ ] On an outpatient basis
   [ ] On an inpatient basis (Hospital, Nursing Home, Hospice)
8. If the patient is an Iowa County employee the serious 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 unable to perform any on of the essential functions of the position. Attached is a job description of the position of the employee.

   a. I have read the employee's job description and am aware of the job functions required for this employee to perform the functions of the position. Below is an explanation of the extent to which the employee is unable to perform those functions as a result of the serious health condition:
      _____

      _____

b. If the employee requires intermittent leave (leave taken in increments of time) or reduced schedule leave (reduces hours of work) which is medically necessary, please describe the regimen of treatment to be provided, the dates on which treatment is expected, and the expected duration of the treatment and leave:
_____

_____

9. The patient was seen by me and treated for this serious health condition on the following date(s):

_____.

10. The medical facts regarding the serious health condition are as follows: _____

_____

11. [ ] Yes [ ] No Has any continuing treatment or supervision been scheduled? If yes, describe:

_____

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, which includes physical and psychological care. A serious health condition for such individual is any condition that affects an individual's ability to engage in normal daily activities.

a. Estimate the period of time care is needed or the employee's presence would be beneficial:
_____

b. If the employee requires intermit leave (leave taken in increments of time) or reduced schedule leave (reduces hours of work) to care for the employee's spouse, son, daughter, or parent, please describe the schedule of treatment and the duration:
_____

_____

Signature of Health Care Provider: I, the undersigned, attest to the truthfulness and accuracy of the above information and affirmatively represent that I, on the above-listed date, did personally undertake a medical examination of the above-named employee.

_____ _____
Print Name of Health Care Provider Signature of Health Care Provider

_____ _____
Telephone Number Date

Definitions:

A "serious health condition" is defined as a disabling physical or mental illness, injury, impairment or condition involving inpatient care in a hospital, nursing home or hospice, or outpatient care the requires continuing treatment or supervision by a health care provider.

A "parent" is defined as a natural parent, foster parent, adoptive parent, stepparent or legal guardian of an employee or an employee's spouse.