NEENAH JOINT SCHOOL DISTRICT
FAMILY AND MEDICAL LEAVE
HEALTH CARE PROVIDER CERTIFICATION

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 where appropriate):

_____ 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: or

_____Prenatal care: or

_____None of the above.

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

_____an employee of the Neenah Joint School District;

_____The spouse of a Neenah Joint School District employee;

_____The son or daughter of a Neenah Joint School District employee; or

_____The parent of a Neenah Joint School district employee.

Accordingly, I certify that:

1. The health condition commenced on _____, 20___ and has a probable duration through _____, 20___.
2. The patient was first seen by me relative to, and treated for, this health condition on_____.
3. The patient experienced the condition on the following dates (or for the specific parts of such days):

_____

_____

4. I have provided/will be providing care to the patient on the following dates. (List all dates of treatment or supervision).

_____

_____

5. What is the expected duration of the treatment and leave (time period during day)?

6. The patient was treated on an **inpatient / outpatient** basis (circle which is applicable)

7. The medical facts regarding the health condition are as follows, including the treatment associated with the condition (**If an outpatient, please state whether there was a regimen of continuing treatment involving prescription medication and/or treatment; if so, please describe the medication and/or other treatment and for what period of time said treatment is/was required):**

8. 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 of the Neenah Joint School District:</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 unable to perform the essential functions of the position.

1. How has the health condition manifested itself for the employee relative to his/her employment?

2. Below is an explanation of the extent to which the health condition impacts the employee's ability to perform the functions of his/her employment position.

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.

<u>If the patient is the spouse, son, daughter or parent of the employee of the Neenah Joint School District:</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, son or daughter on the following dates:

_____

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

_____)

2. Son or daughter's date of birth: _____

3. Describe care to be provided by employee: _____

_____

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

_____

What is the duration of the need for intermittent or reduced leave schedule: _____

_____

Dated this _____ day of _____, 20_____.

_____ _____

Signature of Health Care Provider/Christian Science Practitioner | Telephone Number

_____ _____

Address | City/State/Zip Code

Completed forms can be returned one of the following ways:

- Return to the patient or NJSD employee requesting the leave.
- Email to NJSD Benefits Coordinator, Jen Carstens: Jennifer.carstens@neenah.k12.wi.us
- Fax to NJSD Benefits Coordinator, Jen Carstens: (920) 751-5066

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

Under this authorization, I authorize the above-identified health care provider to provide health information and/or PHI about me to the Neenah Joint School District Department of Human Resources. I understand that after this information is disclosed to the Neenah Joint School District, federal law may not protect it and the Neenah Joint School District may disclose it to others.

I understand that I have the right to revoke this authorization at any time by notifying Jen Carstens, Benefits Coordinator, Neenah Joint School District, 410 South Commercial Street, Neenah, WI 54956, (920) 751-6800 ext 10108. I also understand that the revocation will only become effective after it is received and logged by the Neenah Joint School District. I understand that any use or disclosure made prior to the time that such revocation becomes effective will not be affected by that revocation. Without regard to my right to revoke, this authorization will expire at the end of the latter of the processing or taking of my FMLA leave, unless revoked earlier by me as set forth above.

Dated this _____ day of _____, 20____.

_____

Signature

_____

Name (Print)