APPENDIX E

CERTIFICATION BY HEALTH CARE PROVIDER FOR FAMILY OR MEDICAL LEAVE

EMPLOYEE'S NAME:	**PATIENT'S NAME (if other than employee)**

1. Does _____ have a serious health condition?*

☐ YES (continue with #3) ☐ NO (provide signature and return form to address listed unless #2 applies)

**NOTE: Wisconsin's Family and Medical Leave law (s. 103.10, Wis. Stats.) defines a "serious health condition" as: A disabling physical or mental illness, injury impairment or condition involving either: 1) inpatient care in a hospital, or 2) outpatient care that requires continuing treatment or supervision by a health care provider.*

2. Is _____ eligible and has he/she agreed to serve as a bone morrow or organ done?
(employee)

NOTE: Wisconsin's Bone Marrow and Organ Donation Leave Act (s. 103.11, Wis. Stats.) permits up to six (6) weeks leave in a 12-month period for the purpose of serving as a bone marrow or organ donor, provided that they employee provides his or her employer with certification from a healthcare provider that the done has a serious health condition that necessitates a bone marrow or organ transplant, the employee is eligible and has agreed to serve as a bone marrow or organ donor and the period necessary for the employee to undergo the bone marrow or organ donation procedure and to recover from the procedure.

☐ YES (continue to #3) ☐ NO (provide signature and return form to address below)

3. Date condition commenced or donation is to take place:

4. Probable duration of condition/estimated date employee can return to work:

5. Specify medical facts regarding the serious health condition of employee or done that necessitates a bone marrow or organ transplant (attach additional form if necessary)::

6. Indicate the extent to which the employee is unable to perform his or her employment duties during duration of leave (attach additional form if necessary):

Health Care Provider Name (please print): _____

Type of Practice/Medical Specialty: _____

Business Address: _____

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

_____

Health Care Provider Signature **Date**

Please return completed, signed form to the following address:

Monroe County Personnel Department

124 North Court Street

Sparta, WI 54650

Phone: 608.269.8720

Fax: 608.366.1809

Email: ed.smudde@co.monroe.wi.us

Genetic Information Nondiscrimination Act of 2008 Notification

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law including, but not limited to, to when the employee requests leave for a family member's health condition to (1) document appropriate use of sick leave; and (2) where "family medical history" is required to the extent necessary to make the medical certification complete and sufficient under the FMLA and WFMLA.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information unless it meets the family member exceptions noted above.

'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or individual's family member or embryo lawfully held by an individual or family member receiving assistive reproductive services.