**PHYSICIAN OR PRACTITIONER CERTIFICATION**
**FOR FAMILY OR MEDICAL LEAVE**

Dear Physician or Practitioner:

To assist in establishing leave entitlements under federal and state law, please answer the questions below and return this certification to:

St. Mary Catholic Schools
ATTN: Human Resources – Chelsey Kind
Neenah, WI 54956
ckind@smcatholicschools.org

Employee Name: ____________________________________________________

Patient's Name (if not employee):_________________________________________

Does ______________________________have a serious health condition? [ ] Yes [ ] No

Note: A serious health condition is defined as: an illness, injury, impairment, or physical or mental condition that involves 1) inpatient care; 2) a period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves: treatment two or more times by a health care provider or treatment by a health care provider at least once which results in a regimen of continuing treatment under the health care provider's supervision; 3) any period of incapacity due to pregnancy or for prenatal care; 4) a chronic condition which: requires periodic visits for treatment by a health care provider, continues over an extended period of time, and may cause episodic rather than a continued period of incapacity (e.g. asthma, diabetes, epilepsy, etc.); 5) a period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. A person must be under the continuing supervision of, but need not be receiving active treatment by a health care provider (e.g. Alzheimer's Disease, severe stroke, terminal stages of cancer, AIDS, etc.); 6) any period of absence to receive multiple treatments for restorative surgery after an injury or for a condition that would likely result in a period of incapacity of more than three calendar days in the absence of medical intervention (e.g. chemotherapy, kidney dialysis, etc.)

What date did the condition begin? _____________________________________________

What is the probable duration of this condition? ____________________________________

_________________________________________________________________________

Specify medical facts regarding the serious health condition (diagnosis not required). ________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please indicate the extent to which the employee is unable to perform the functions of his/her job: ________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Physician/Practitioner Name: ____________________________________________________
(Please Print)
Physician/Practitioners' Signature: _____________________________ Date: _______________