This is a fill-in form. Please click on the appropriate area to enter information. Tab between fields and PRINT when completed.

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DIVISION OF PERSONNEL MANAGEMENT
DOA-15323 (C07/2015)
S.103.10, WIS. STATS.
PREVIOUSLY OSER-DCLR-202

COMPENSATION & LABOR RELATIONS
101 E. WILSON ST, 4TH FL
MADISON, WI 53703

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?***
(patient)

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

***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. **Date condition commenced:**

3. **Probable duration of condition:**

4. **Specify medical facts regarding the serious health condition:**

5. **Indicate the extent to which the employee is unable to perform his or her employment duties:**

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:

_____

_____

Print Form Clear Form