City of Madison

FAMILY / MEDICAL LEAVE OF ABSENCE
PROVIDER CERTIFICATION

Employee - Birth, Adoption, or Foster Care Placement of Child or Care for such Child

Employee: Complete and submit the Application for Family/Medical Leave as soon as possible when the need for absence is known and at least 30 days in advance of the expected start of leave. Page 2 of the application is to be submitted to your department. Page 1 of the application and this Provider Certification form are to be submitted to the Human Resources Department. Notify your department and Human Resources immediately when leave time is first used.

TO BE COMPLETED BY THE EMPLOYEE BIRTH PARENT (MOTHER OR FATHER), ADOPTIVE OR FOSTER CARE PARENT (MOTHER OR FATHER)

I request leave for pregnancy or birth of my child or for placement of a child with me for adoption or foster care.

I request that the responsible health or birth care provider, adoption service provider or foster care authority provide the expected date of delivery or placement.

Employee Name (print or type) _____ Employee's Department _____

Employee Signature _____ Date of Request _____

TO BE COMPLETED BY THE HEALTH OR BIRTH CARE PROVIDER, ADOPTION SERVICE PROVIDER OR FOSTER CARE AUTHORITY

Expected date of delivery, date of adoption placement or foster care placement _____

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 employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. '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 an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PROVIDER INFORMATION

Name and Address of Health Care Provider: _____

_____

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_____

Signature of Provider _____

Please return form to: CONFIDENTIAL-BENEFITS
HUMAN RESOURCES DEPARTMENT
215 MARTIN LUTHER KING JR BLVD STE 261
MADISON WI 53703
FAX 608-267-1115