CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS – FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's name WILLIAM MASON

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.*

(1) _____ (2) _____ (3) _____ (4) _____ (5) X (6) _____ None of the above _____

Describe the medical facts and/or treatment that meet the criteria of the serious health condition checked above (Medical diagnosis/prognosis is not required): MR. MASON IS BEING TREATED FOR A BLOOD AND IS UNDER MY SUPERVISION.

Date condition commenced: NOVEMBER 2008

Probable duration of condition: LIFETIME

Probable duration of present incapacity (if different): ONE TO SIX MONTHS

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment (e.g. follow-up treatment) of the employee's serious health condition, including pregnancy? _____ **Yes** X **No**

If so, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:

Dates: _____

Duration: _____ **hour(s) or** _____ **day(s) per episode.**

Period of Recovery: _____

Will the employee require leave on an intermittent or reduced schedule basis for the employee's serious health condition, including pregnancy, that may result in unforeseeable episodes of incapacity (e.g. flare ups)? _____ **Yes** X **No**

If so, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: _____ **times per** _____ **week(s)** _____ **month(s):**

Duration: _____ **hour(s) or** _____ **day(s) per episode.**

Is the employee able to perform the essential functions of employee's position? X **If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.**

MR. MASON WILL NOT BE ABLE TO RETURN TO DUTY.

Health Care Provider's Name (Please print): PHILIP BROWN, MD

Health Care Provider's Signature: S/ PHILIP BROWN, MD **Date:** 4/15/09

Address: 915 MADISON ST MILWAUKEE WI 50600

Phone number: 234-098-7654 **Fax number:** 234-456-8910

Specialty/Type of Practice: INTERNAL MEDICINE