RETURN FORM TO:

Human Resources Department
7525 West Greenfield Avenue
West Allis, Wisconsin 53214
Fax: 414-302-8275
Email: hr@westalliswi.gov
Phone: 414-302-8270

CITY OF WEST ALLIS

HEALTH CARE PROVIDER

BONE MARROW and ORGAN DONATION LEAVE CERTIFICATION FORM

Per Section 103.11 Wis. Stats., an eligible employee may take leave for the period necessary to undergo a bone marrow or organ donation procedure and to recover from the procedure; no more than 6 weeks of leave in a 12-month period may be taken.

Name of Employee Requesting Leave: _____
(PRINT NAME: FIRST MI LAST)

THE FOLLOWING IS TO BE COMPLETED BY THE HEALTH CARE PROVIDER ONLY

Dear Health Care Provider: Please complete this form so the City of West Allis may determine the employee's eligibility as defined under Section 103.11 Wis. Stats.

Please Type or Print Legibly

I, _____, **certify as follows**:
(Name of Health Care Provider)

1. _____ has a serious health condition that necessitates a bone marrow or organ transplant.
(Donee's Name)

2. _____ is under my care, is eligible, and has agreed to serve as a bone marrow or organ donor for _____.
(Employee's Name) (Donee's Name)

3. _____ will need to be off from work for the bone marrow or organ donation procedure and to recover from said procedure, as specified, on the following dates:_____
(Employee's Name)
_____
_____
_____

4. I expect the employee may return to work on (date) _____

_____, _____/_____/_____
Printed Name of Health Care Provider | Street Address | City | State & Zip Code

_____ _____ _____
Date | Signature of Health Care Provider | Telephone Number