UW-La Crosse
Certification of Medical Necessity

Faculty, Academic Staff and Limited Appointment employees of UW-La Crosse are required to provide certification of medical necessity (CMN) for sick leave absences of more than 5 consecutive full working days, within 15 days of their return to work. Contact UW-L HR (608-785-8013) for complete explanation of the policy and exceptions.

1. *THIS SECTION TO BE COMPLETED BY EMPLOYEE, shared with their health care provider to complete section 2 and then delivered to their UW-L supervisor.*

UW-L Employee Name PRINT PLAINLY		Requested CMN from health care provider: _____/_____/_____ (mm/dd/yyyy)
UW-L Dept/Units:	Employee Signature:	

2. *THIS SECTION TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER and returned to patient. The patient is responsible for delivery to their direct UW-L Supervisor.*
Do NOT provide any confidential medical information.

I certify that the above-named person's absence from work was due to medical necessity, beginning

on _____ (insert date) and ending on _____ (insert date) and that s/he was medically able to return to work on _____ (insert date).

Health Care Provider Name—**PRINT**	Health Care Provider Job Title; License/Type-**PRINT**	Date Signed
Health Care Provider Signature	Agency/Institution/Business Name-**PRINT**	_____ (mm/dd/yyyy)

THIS SECTION TO BE COMPLETED BY UW-L ADMINISTRATION and delivered to: the Office of Human Resources, 144 Graff Main Hall

Supervisor **PRINT** NAME:_____	**Supervisor**—IF more than one **PRINT** NAME:_____
_____ _____ Signature Date (mm/dd/yyyy)	_____ _____ Signature Date (mm/dd/yyyy)
Dean/Division Officer **PRINT** NAME:_____	**Dean/Division Officer--**IF more than one **PRINT** NAME:_____
_____ _____ Signature Date (mm/dd/yyyy)	_____ _____ Signature Date (mm/dd/yyyy)

HR Office Use Only:

Date Received: _____ HR Initials: _____ In HR Office

Dates of Absence Confirmed: Y N W/Unclassified Leave Reports HR Initials: _____

SL Audit Completed & Verified By HR:_____ (Name of HR Staff Member)

Completed Date:_____