CITY OF MILWAUKEE

2008 JUN 16 AM 11:34

RONALD D. LEONHARDT
CITY CLERK

CLAIM AGAINST THE CITY OF MILWAUKEE
BY ROBERT E. ROZGA

CITY OF MILWAUKEE
RECEIVED
2008 JUN 16 PM 2:52
OFFICE OF
CITY ATTORNEY

I (ROBERT E. ROZGA) AM FILING THIS CLAIM AGAINST THE CITY OF MILWAUKEE FOR THE DOLLAR AMOUNT OF $25,000 FOR THE FOLLOWING REASONS:

ON MARCH 3 2008 I HAD A SLIP AND FALL ACCIDENT IN THE CITY'S EMPLOYEE PARKING LOT AT 3850 N. 35TH ST.(TOWER SITE) WHICH CAUSED BODILY INJURY TO MY UPPER BACK AND NECK (SEE ACCIDENT REPORT). I HAD SEEN DR.L. DOLNZYNSK THE FOLLOWING DAY AND HE HAD X-RAYS TAKEN. DR. DOLNZYNSK HAD EXCUSED ME FROM WORK FOR 4 (FOUR)DAYS DUE TO THE INJURY AND HAD ALSO PERSCRIBED MEDICATION FOR THE PAIN AND DISCOMFORT. WHEN I HAD NOTIFIED TOM RACH, BY PHONE THAT I WAS GOING TO BE OFF OF WORK FOR 4 (FOUR) DAYS HE TOLD ME TO USE SICK LEAVE AND VACATION TIME FOR THE DAYS THAT I WAS GOING TO BE ABSENT. HE ALSO MADE A STATEMENT THAT I WASN'T PULLING WHAT I DID TO MY PREVIOUS SUPERVISOR, MARCIA LINDHOLM. (I SUFFER FROM DEPRESSION AND MILD ANXIETY AND NEED TO TAKE FAMILY LEAVE FOR PERIODS OF TIME, SOMETHING THAT I CANNOT CONTROL) UPON RETURNING TO WORK ON THE 9TH OF MARCH I ASKED HIM FOR A WORKMAN'S COMPENSATION FORM WHICH HE GAVE ME. I FILLED OUT THE CLAIM FORM WHICH I RETURNED TO HIM THE SAME DAY AND ALSO A DR.'S EXCUSE FORM WHICH HE REQUESTED. TOM RACH (MY SUPERVISOR AT THE TIME) IS NOW RETIRED. APPROXIMATELY ONE MONTH LATER I HAD CALLED GERALDINE WATSON WHO WORKS WITH WORKMAN COMP CLAIMS TOLD ME THAT SHE WOULD LOOK INTO THE CLAIM. APPROXIMATELY ONE WEEK LATER I HAD CALLED HER AGAIN AND WAS TOLD BY HER THAT THERE WAS NO RECORD OF A CLAIM BEING MADE BY ME. I RESUBMITTED THE CLAIM TO HER OFFICE APPROXIMATELY 6 (SIX) WEEKS AFTER THE INJURY OCCURRED. WHEN I CALLED HER ONE WEEK LATER SHE TOLD ME THAT THE CLAIM HAD BEEN HANDED OVER TO PAT MAGLIATCHO AND GAVE ME THE FILE NO 080982PM. SINCE THEN I HAD CALLED MR. MAGLIACCI REPEATEDLY TO FIND OUT WHAT THE DISPOSITION WAS OF THE CLAIM AND WAS ONLY ABLE TO GET HIS VOICE MAIL. I HAD LEFT MESSAGES ON HIS VOICE MAIL ALONG WITH MY CELL PHONE NUMBER BECAUSE I WORK IN THE FIELD MOST OF THE TIME AS AN ENGINEERING TECHNICIAN WITH A SURVEY CREW.

THE CLINIC I WENT TO THE DAY AFTER THE FALL HAD SENT ME A BILL FOR THE CO-PAY OF THE DR.'S VISIT AND THE X-RAYS THAT WERE TAKEN. AFTER CALLING THE CLINIC ABOUT THE BILL FOR CO-PAY I FOUND OUT THAT MY HMO HAD PAYED THE BILL AND THAT THERE IS NOW A $0.00 BALANCE.

I AM OUT 13.2 SICK LEAVE HOURS AND 18.8 VACATION HOURS BECAUSE TOM RACH HAD TOLD ME TO USE **MY** TIME FOR THE PERIOD THAT I WAS OFF.

UPON RETURNING TO WORK I WAS STILL SORE, BUT RETURNED TO MY USUAL DUTIES WORKING OUTDOORS **AND** IN INCLEMANT WEATHER.

I HAVE WORKED AT THE TOWER SITE THROUGH THE WINTER OF 2007 AND HAVE WITNESSED ON A DAILY BASIS A SALT TRUCK CONTINUOUSLY WEAVING BETWEEN THE PARKED CARS SPREADING SALT ON TOP OF THE SALT ALREADY ON THE BLACK TOP PARKING SURFACE. WHEN THE CITY'S AMOUNT OF SALT STARTED TO DWINDLE, THERE WAS NO MORE SALTING BEING DONE TO THE PARKING AREA. THIS WAS AT A TIME WHERE THE SNOW MELT WAS FREEZING AND THAWING AND THE THREAT OF BLACK ICE BECAME EVIDENT. MY FALL WAS WITNESSED BY 2 OTHER EMPLOYEES AND AT THE SAME TIME THAT I FELL, ONE OTHER EMPLOYEE HAD SLIPPED ON THE ICE THE SAME TIME THAT I FELL.

I HAVE NO WAY OF KNOWING WHAT THE STATUS IS OF MY WORKMAN'S COMPENSATION CLAIM IS AND THE TIME LIMIT FOR ME TO FILE CLAIM AGAINST THE CITY ENDS ON MARCH 31,2008.

MY TIME AWAY FROM WORK IS VERY IMPORTANT TO ME AS WELL AS MY TIME WORKING FOR THE CITY. I LIKE THE JOB THAT I HAVE WITH THE CITY BECAUSE IT MAKES ME FEEL GOOD AT THE END OF THE DAY. I HAVE A SENSE OF HAVING ACCOMPLISHED SOMETHING. I ALSO ENJOY HAVING MY OWN COMPANY BECAUSE IT WILL ENABLE ME TO SUPPLIMENT MY INCOME WHEN I DO RETIRE.

I RESENT THE COMMENT MADE BY TOM RACH ABOUT "PULLING ANYTHING" BECAUSE I HAVE BEEN UNDER DR'S CARE FOR APPROXIMATELY 4 YEARS FOR MY ILLNESS. I UNDERSTAND THE IMPORTANCE OF ME TO BE AT WORK BUT I HAVE USED UNPAID LEAVE FOR FAMILY LEAVE AND FAIL TO SEE HOW MY ABSENCE FROM WORK WORKS TO MY ADVANTAGE.

MY CLAIM AGAINST THE CITY OF MILWAUKEE FOR FAILURE TO CONTINUE SALTING OPERATIONS IN THE PARKING LOT AT THE TOWER SITE IS MORE THAN FAIR. I AM SUING THE CITY OF MILWAUKEE FOR THE DOLLAR AMOUNT OF $25,000 FOR PAIN AND SUFFERING AND NEGLECTING TO KEEP ME INFORMED OF MY WORKMAN'S COMP. CLAIM AND FOR THE VACATION AND SICK LEAVE I HAD TO USE FOR THIS ACCIDENT. I ALSO SUFFER FROM DEPRESSION AND MILD ANXIETY AND OCASSIONALY I HAVE TO USE FAMILY LEAVE WHICH IS PAID FOR OUT OF MY VACATION AND SICK LEAVE OR FOR NO PAY AT ALL. I HAVE ALREADY TAKEN DAYS OFF WITH FAMILY LEAVE FOR NO PAY BECAUSE OF MY LACK OF SICK LEAVE AND THE FEW VACATION HOURS THAT I HAVE LEFT FOR THIS YEAR.

CONTENTS OF THIS CLAIM ARE LISTED BELOW

1)THE ORIGINAL CLAIM ENTITLED "CLAIM AGIANST THE CITY OF MILWAUKEE".

2)COPY OF SICK LEAVE REQUEST.

3)COPY OF WORKMAN'S COMPENSATION APPLICATION.

4)COPY OF DR.'S EXCUSE.

5)COPY OF TIME CARD SHOWING SICK LEAVE AND VACATION TIME USED FOR BEING ABSENT FROM WORK.

6)TWO PAGE COPY OF BILLING ACCOUNT FROM LAKESHORE MEDICAL.

7)COPY OF F.M.L.A. DOCUMENT.

8)COPIES OF TIME CARDS SHOWING DAYS TAKEN OFF OF WORK DUE TO F.M.L.A.

MY NAME IS:
ROBERT EDWARD ROZGA
3334 S. GRIFFIN AVE.
MILWAUKEE WI. 53207
CELL PHONE: (414)581-2090

CLAIM APPLICANT
ROBERT E. ROZGA
JUNE 9TH 2008

CBP-156
REV. 1-95

YELLOW - DEPARTMENT

CITY OF MILWAUKEE

APPLICATION FOR SICK LEAVE ☐ or INJURY PAY ☒

WERE YOU INJURED ON JOB? YES

NAME — FIRST: ROBERT E. LAST: KOZA

ADDRESS: 3334 S. GRIFFIN AV.

TITLE: ENG. TECH II

PENSION NUMBER: 53186

DEPT/DIV.: DPW / CONSTRUCTION

INSTRUCTIONS: IF ABSENT FOR MORE THAN THREE WORKING DAYS, A DOCTOR'S CERTIFICATE CONTAINING THE FOLLOWING INFORMATION IS REQUIRED:
1. STARTING AND ENDING DATES OF ABSENCE.
2. NATURE OF ILLNESS OR INJURY.
3. WHETHER OR NOT THE APPLICANT WAS ABLE TO WORK.

NOTE: SICK LEAVE CERTIFICATION (FORM CBP 157) MAY BE COMPLETED BY YOUR DOCTOR TO VERIFY YOUR ABSENCE. IT CAN BE OBTAINED FROM YOUR PAYROLL CLERK.

PERIOD ABSENT FROM WORK: (IF LESS THAN ONE FULL WORKING DAY, COMPLETE LINE 2. BELOW)

	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
1. FROM	3	4	08	THRU	3	7	08	NUMBER OF WORKING DAYS ABSENT 4.

2. PARTIAL DAY ABSENCE — FROM (MONTH DAY YEAR) : TO : NUMBER OF HOURS

NATURE OF ILLNESS OR INJURY: INJURY TO BACK/NECK DUE TO SLIP/FALL IN DPW PARKING LOT

DID YOU REMAIN IN YOUR HOME DURING THE FULL PERIOD OF ILLNESS OR INJURY, INCLUDING EVENING HOURS, EXCEPT FOR VISITS TO THE DOCTOR? YES ☒ NO ☐ IF ANSWER IS NO, EXPLAIN BELOW

DID YOU RECEIVE MEDICAL ATTENTION FROM A DOCTOR DURING THE ABOVE PERIOD? YES ☒ NO ☐

DOCTOR'S NAME L. DOLNZYNSK ADDRESS 5900 S. LAKE DR.

DID YOU NOTIFY YOUR SUPERIOR IN ACCORDANCE WITH YOUR DEPARTMENTAL REGULATIONS? YES ☒ NO ☐

FALSE OR MISLEADING STATEMENTS WILL BE CONSIDERED CAUSE FOR SUSPENSION OR DISCHARGE.

THE ABOVE STATEMENTS ARE TRUE AND CORRECT:

APPLICANT'S SIGNATURE [signature] DATE 3-10-08

THIS SECTION FOR DEPARTMENTAL APPROVAL

I HAVE REVIEWED THIS APPLICATION FOR ACCURACY AND COMPLETENESS AND PAYMENT IS APPROVED: SIGNATURE DATE

GAVE TO T. RACH ON 3-10-08

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

,005

REPORT OF ACCIDENT TO EMPLOYE
UNDER WORKER'S COMPENSATION ACT

...NT REGULARLY WORKED IN	EMPLOYE HEALTH PLAN	IS THIS EMPLOYE ELIGIBLE FOR INJURY PAY?	
DPW	UNITED HEALTH	☒ YES	☐ NO
...e of Witnesses		HOW IS EMPLOYE BEING PAID? INJURY ☐	SICK ☒ NO-PAY ☐
Jeffrey Luecking			

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. **See instructions for completing this form on reverse side.**

EMPLOYE

Employee Name (First, Middle, Last)	Social Security Number	Sex	Employee Home Telephone No.
ROBERT E. ROZGA	397-60-6728	☒ M ☐ F	414-581-2090

Employee Street Address	City	State	Zip Code	Occupation
3334 S. GRIFIN AVE	Milwaukee	WI	53207	ENG TECH

Birthdate Mo.	Day	Year	Date of Hire	County and State where accident or exposure occurred.
1	13	55	3-90	MILWAUKEE WI.

EMPLOYER

Employer Name	WI Unemployment Insurance Account No.	Self-Insured?	Nature of business (specific product)
City of Milwaukee	69137	☒ Yes ☐ No	Municipality

Employer Mailing Address	City	State	Zip Code	Employer FEIN:
200 E. Wells St. - Room 701	Milwaukee	WI	53202	396005532

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN:
City of Milwaukee	396005532

Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer.	TPA FEIN:
NA	NA

WAGE INFORMATION

Wage at Time of Injury:	Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received:		No. of Meals/wk.
$ 20.84	Per. Weekly HRLY	☐ Meals ☐ Room ☐ Tips		No. of Days/wk.
				Av. Weekly Amt. $

Is worker paid for overtime? ☒ Yes ☐ No If yes, after how many hours of work per week? 40

For the 52 week period prior to the date the injury occurred, report below the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.

No. of Weeks:	Gross Amount Excluding Tips	If Piece Work - No. of Hrs. excluding overtime
49	$ 43,000	

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	☒ AM ☐ PM	8	40	5
Employer's Usual Full-Time Schedule For This Type of Work At Time of Employee's Injury:				

Part-Time Employment Information	Are there other part-time workers doing the same work with the same schedule? ☐ Yes ☐ No If yes, how many?	Number of full-time employees doing the same type of work.

INJURY INFORMATION

Injury Date	Time of Injury	Last Day Worked	Date Employer Notified	
3-3-08	AM 3:45 PM	3-3-05	3-5-08	☒ Date Returned to Work ☐ Estimated Date of Return 3-10-08

Did injury cause death?	Date of Death	Was this a lost time or other compensable injury?	Did injury occur because of:			
☐ Yes ☒ No		☒ Yes ☐ No	☐ Substance Abuse	☐ Failure to Use Safety Devices	☐ Failure to Obey Rules	

Was employee treated in emergency room? ☐ Yes ☒ No — Was employee hospitalized overnight as an in-patient? ☐ Yes ☒ No

Name and Complete Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe activities of the employee when the injury or illness occurred and what tools, machinery, objects, chemicals, etc. that were involved.

AFTER I LEFT THE BUILDING TO GO HOME AT 3:45, 3-3-08, I SLIPPED ON A PATCH OF BLACK ICE ON THE ASPHALT PARKING LOT, AND LANDED FLAT ON MY BACK BEFORE I GOT TO MY TRUCK.

What happened to cause this injury or illness? (Describe how the injury occurred)

A PATCH OF "BLACK ICE" ON THE ASPHALT PARKING LOT

What was the injury or illness? (State the part of the body affected and how it was affected) NECK, SORE & STIFFNESS TO BACK (UPPER) &

Report Prepared By:	Work Phone	Position:	Date Signed:
ROBERT E ROZGA	286-6237	APPLICANT - ENG. TECH II	3-10-08

SEND REPORT IMMEDIATELY. DO NOT WAIT FOR MEDICAL REPORT

LAKESHORE MEDICAL CLINIC, LTD.

N HEALTH CENTER
. Capitol Drive
.ukee, WI 53216
ne: 414-449-2114

.UDAHY CAMPUS
At St. Luke's South Shore
5900 S. Lake Drive
Cudahy, WI 53110
Phone: 414-489-4190

☐ **SOUTHPOINTE FAMILY PRACTICE**
4448 W. Loomis Road, Suite 100
Greenfield, WI 53220
Phone: 414-281-5150

☐ **LAYTON AVENUE CAMPUS**
Lakeshore Medical Clinic
2000 E. Layton Avenue
St. Francis, WI 53235
Phone: 414-744-6589

☐ **MUSKEGO CAMPUS**
S74 W16775 Janesville Road
Muskego, WI 53150
Phone: 414-422-2180

☐ **THIRD WARD CAMPUS**
180 N. Milwaukee Street
Milwaukee, WI 53202
Phone: 414-227-1127

☐ **WOMEN'S PAVILION**
8905 W. Lincoln Ave, Suite 409
West Allis, WI 53227
Phone: 414-328-8770

☐ **NEW BERLIN CAMPUS**
14555 W. National Avenue
New Berlin, WI 53151
Phone: 262-827-2959

☐ **OAK CREEK CAMPUS**
331 E. Puetz Road
Oak Creek, WI 53154
Phone: 414-570-3590

☐ **20TH & OHIO CAMPUS**
Lakeshore Medical Clinic
3305 S. 20th Street
Milwaukee, WI 53215
Phone: 414-645-1808

☐ **WEST ALLIS CAMPUS**
Lakeshore Medical Clinic
2424 S. 90th Street
West Allis, WI 53227
Phone: 414-328-8777

☐ **SOUTH POINTE INTERNAL MEDICINE**
4448 W. Loomis Road, Sutie 206
Greenfield, WI 53220
Phone: 414-281-1688

☐ **SOUTH MILWAUKEE**
3611 S. Chicago Ave. Ste. 100
South Milwaukee, WI 53172
Phone: 414-762-7270

☐ **SOUTHPOINTE OB/GYN**
4448 W. Loomis Road, Suite 201
Greenfield, WI 53220
Phone: 414-817-0784

Please excuse Robert Rozga From: ☒ Work ☐ School ☐ Gym/Sports ☐ Other: _____

First Day Off 3-4 Patient was here today 3-5 for an appointment

Return to Work/School/Activities Date 3-10 NEXT CLINIC APPOINTMENT _____

Restrictions If Any _____

Remarks: please excuse

Dr. Rebancos/L. Dabrzynska CMA 3-7-08
Signature Date

Timecard for ROZGA,ROBERT E (005359) for PayPeriod 5 of year 2008

Name: ROZGA,ROBERT E
Mgr OK: 001786
Clk OK: 011948

Emplid: 005359
Empl type: Hourly
Total hrs: **80.0**

				0.0	8.0	8.0	8.0	8.0	8.0	0.0	40.0	0.0	8.0	8.0	8.0	8.0	8.0	0.0	40.0
Account code	JobCd	Ern	Sft	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Wk1	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Wk2
0425	1885DC	077			2.0	8.0			8.0		18.0		4.0						4.0
478HSM495080001	1885DC	077			4.0		4.0	8.0			16.0		4.0						4.0
478LSM495060052	1885DC	077			2.0						2.0								0.0
9900	1885DC	243					4.0				4.0								0.0
9900	1885DC	043									0.0			8.0	5.2				13.2
9900	1885DC	042									0.0				2.8	8.0	8.0		18.8

PLSJTOD

STATEMENT OF PHYSICIAN SERVICES

ACCOUNT NUMBER: 27044098

FOR APPOINTMENTS CALL: 414-541-7410

FOR BILLING QUESTIONS: 414-768-1845 OR 414-764-3766

AMOUNT DUE: 0.00

#27044098#
ROBERT E ROZGA
3334 S GRIFFIN AVE
MILWAUKEE,WI 53207-2740

MAKE CHECKS PAYABLE TO:

LAKESHORE MEDICAL CLINIC
PO BOX 371280
MILWAUKEE,WI 53237-2380

PHYSICIAN / FACILITY	SERVICE DATE	SERVICE CODE	DESCRIPTION	TRANSACTION DATE	INSURANCE ACTIVITY	PATIENT ACTIVITY
LAMBERTON MD,STEPHE			INVOICE: 44485071			
LAKESHORE CUDAHY			ROZGA,ROBERT E			
	03/05/08	99213	OFFICE/OUTPATIENT VISIT			140.00
			COMMERCIAL BILLED	03/12/08		
	03/05/08		UNITEDHEALTHCARE PAYMENT AMOUNT:	04/28/08	- 118.52	
			INSURANCE CONTRACT DISCOUNT AMOUNT:		- 21.48	
KLEIN MD,MITCHELL A			INVOICE: 44485072			
LAKESHORE CUDAHY			ROZGA,ROBERT E			
	03/05/08	72050	XRAY: SPINE			205.00
			COMMERCIAL BILLED	03/12/08		
	03/05/08		UNITEDHEALTHCARE PAYMENT AMOUNT:	04/28/08	- 98.69	
			INSURANCE CONTRACT DISCOUNT AMOUNT:		- 106.31	

INSURANCE BALANCE 0.00

ACCOUNT NUMBER: 27044098

GUARANTOR NAME: ROZGA,ROBERT E AMOUNT DUE: 0.00

INSURANCE SUMMARY		EFF	TERM
INSURANCE COMPANY NAME	POLICY/GROUP NUMBER	DATE	DATE
UNITED HEALTH CARE 38	XXXXXXXXX/712481	01/01/08	
HUMANA EMPHESYS 1	HXXXXXXXX/Q0405006A940	703/26/07	12/31/07
COMPCARE AURORA FAMILY	ZRTXXXXXXXXX/0011462FH0	101/01/03	02/28/07

City of Milwaukee

Medical Certification Under the Family & Medical Leave Acts (FMLA)

This medical certification must be provided for all requests for FMLA leave for the serious health condition of the employee or the employee's spouse, parent, or child.

Part A *(To be completed by the Employee):*

Employee: ROBERT E. ROZGA	**Job Title:** DT II
Department: DPW	
Division: TRANSPORTATION	**PeopleSoft ID #:** 005359
Patient's name: SAME AS ABOVE	
Relationship to Employee *(If other than employee):*	**Patient's Age** *(If patient is a child of the employee):*

Part B *(To be completed by the Health Care Provider)*

Please complete this information to allow the employee's request to be approved. The Family & Medical Leave Acts define a serious health condition as illness, injury, impairment or physical or mental condition that involves one or more of the following. Please identify the categories under which the patient's condition qualifies.

☐ **Hospital Care**—Inpatient care *(i.e., an overnight stay)* in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care. *For purposes of this section incapacity is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.*

Absence Plus Treatment—A serious health condition involving continuing treatment by a health care provider that includes a period of incapacity, and any subsequent treatment or period of incapacity relating to the same condition that also involves: *(Incapacity defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.)*

☑ **1.** Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services *(e.g., physical therapist)* under orders of, or on referral by, a health care provider; OR

☑ **2.** Treatment by a health care provider on at least one occasion that results in a regimen of continuing treatment under the supervision of the health care provider.

☐ **Pregnancy**—Continuing treatment by a health care provider for any period of incapacity due to pregnancy, or for prenatal care.

Chronic Condition Requiring Treatment—Continuing treatment by a health care provider for any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one that:

☑ **1.** Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

☑ **2.** Continues over an extended period of time *(including recurring episodes of a single underlying condition)*; and

☑ **3.** May cause episodic rather that a continuing period of incapacity *(e.g., asthma, diabetes, epilepsy, etc.)*

☐ **Permanent/Long Term Condition Requiring Supervision**—A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. *Examples include Alzheimer's, a severe stoke, or the terminal stages of a disease.*

☐ **Multiple Treatments/Non-Chronic Condition**—Any period of absence to receive multiple treatments *(including any period of recovery therefrom)* from a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer *(chemotherapy, radiation, etc.)* severe arthritis *(physical therapy)*, kidney disease *(dialysis)*.

City of Milwaukee also requires the following information from the Health Care Provider in order to ermine the employee's eligibility for FMLA. If this information is not provided, the leave will be denied.

)	Identify and briefly describe the serious health condition: Depression	
2)	Date the serious health condition commenced: 4/4/02	Date of probable end of care: *Must indicate a date unless the condition is chronic.* continous at least through 12/31/07
	Probable duration of present incapacity if different from date of probable end of care: *(Such as inability to work, attend school, or perform other daily activities due to the serious health condition, treatment therefore or recovery therefrom.) Must indicate an ending date unless the condition is chronic.*	
3)	Is this a chronic condition? YES ☑ NO ☐	If this is a chronic condition, what is the likely frequency of episodes of incapacity? indeterminate
4)	Within the knowledge of the health care provider or Christian Science practitioner, provide the medical facts regarding the serious health condition that support this medical certification. *Please attach a separate sheet if more space is necessary.* Depression ; which effects mood and function	
5)	If this is family leave, is the employee needed to provide assistance for basic medical or personal needs of safety, or for transportation, or for medical appointments, or making arrangement for care? *Please specify what care the employee will provide.* N/A	
6)	Will it be necessary for the employee to take leave intermittently or to work on a reduced leave schedule (part-time) as a result of the serious health condition? YES ☑ NO ☐	Probable duration of an intermittent or reduced leave schedule: *Please provide an ending date if possible.* ≥ 2 years (subject to revision)
7)	For medical leave (employee's own serious health condition), an explanation of the extent to which the employee is unable to perform his/her employment duties. *Please indicate employee's limitations and the anticipated duration of the restrictions.* Had been medically off of work, now requires periodic outpatient appointments and occasional "breaks", in order to enhance function/well being.	

Health Care Provider's Signature:	***Date:*** 1/8/07
Health Care Provider's Name: (please print) ROBERT L. LOIBEN, M.D. WINSTON CLINICS, S.C. 9720 W. BLUEMOUND ROAD MILWAUKEE, WI 53226	***Health Care Provider's Title:*** Psychiatrist
Health Care Provider's Address: ROBERT L. LOIBEN, M.D. WINSTON CLINICS, S.C. 9720 W. BLUEMOUND ROAD MILWAUKEE, WI 53226	***Health Care Provider's Telephone Number:*** 414 774.1794

Distribution:

- Original – Approving Department
- Employee
- Payroll Assistant

Rev. 9/03

Timecard for ROZGA,ROBERT E (005359) for PayPeriod 11 of year 2008

Name: ROZGA,ROBERT E
Mgr OK: 002213
Clk OK: 011948

Emplid: 005359
Empl type: Hourly
Total hrs: **72.0**

				0.0	8.0	8.0	8.0	8.0	8.0	0.0	40.0	0.0	8.0	0.0	8.0	8.0	8.0	0.0	32.0
Account code	JobCd	Ern	Sft	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Wk1	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Wk2
478HSM495070098	1885DC	077			8.0						8.0								0.0
492MST211090107	1885DC	077				8.0	8.0	3.0			19.0				8.0	8.0	8.0		24.0
492MST211080001	1885DC	077						5.0			5.0								0.0
9900	1885DC	042							8.0		8.0								0.0
9900	1885DC	045									0.0		8.0						8.0

Timecard for ROZGA,ROBERT E (005359) for PayPeriod 12 of year 2008

Name: ROZGA,ROBERT E
Mgr OK: [NONE]
Clk OK: [NONE]

Emplid: 005359
Empl type: Hourly
Total hrs: **56.0**

				0.0	8.0	8.0	8.0	8.0	8.0	0.0	40.0	0.0	0.0	0.0	0.0	8.0	8.0	0.0	16.0
Account code	JobCd	Ern	Sft	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Wk1	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Wk2
492MST211080001	1885DC	077			8.0	8.0	8.0				24.0					8.0	8.0		16.0
9900	1885DC	042						8.0	8.0		16.0								0.0