

For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTHCARE PROVIDER: The employee listed on page 1 has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of the condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs to leave. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Providers name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? _____ No _____ Yes If so, dates of admission: _____

Date(s) you treated the patient per condition: _____

Was medication, other than over-the-counter medication, prescribed? _____ No _____ Yes

Will the patient need to have treatment visits at least twice per year due to the condition?
_____ No _____ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? _____ No _____ Yes. If so, state the nature of such treatments and expected duration of treatment: _____

2. Is the medical condition pregnancy? _____ No _____ Yes If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatments such as the use of specialized equipment): _____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery, _____ No _____ Yes

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will patient need care? _____ No _____ Yes

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? _____ No _____ Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced scheduled basis, including any time for recovery? _____ No _____ Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary: _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____ No _____ Yes

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1–2 days):

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

Duration: _____ hours or _____ day(s) per episode

Does the patient need care during these flare-ups? _____ No _____ Yes

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: Identify question number with your additional answer.

Signature of Healthcare Provider

Date