

Describe the care you will provide to your family member and estimate the leave needed to provide such care:

Employee signature

Date

To be completed by health care provider:

The employee listed above 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 a condition, treatment, etc. Your answer should be the 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 leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3 (f), C.F.R. § 1635.3 (b). Extra space is provided, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice/medical specialty: _____

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

E-Mail:

Medical Facts

1. The approximate date the condition commenced: _____

The probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?

Yes No If yes, dates of admission: _____

List date(s) you treated the patient for their condition _____

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

Will the patient need to have treatment visits at least twice per year due to the condition?

Yes No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)?

Yes No

If yes, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? Yes No

If yes, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis or any regimen of continuing treatment such as the use of specialized equipment):

Amount of leave needed

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

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

If yes, estimate the beginning and ending dates for the period of incapacity: _____

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

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

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

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: _____

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

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: _____

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

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 six months (e.g. one episode every three months lasting one to two days):

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

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

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

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

Additional Information – (Identify the question number with your additional answer):

Signature of Health Care Provider

Date