

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 employee is seeking leave. Please be sure to sign the form on the last page. Unanswered or partial responses may result in your patient having to bring this form back for completion.

Provider's name: _____

Business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____

FAX: (_____) _____

PART A: MEDICAL FACTS:

Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

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

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

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

No Yes

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

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

2. Is the medical condition pregnancy? No Yes

If yes, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: No

Yes **If yes,** identify the job functions the employee is unable to perform: _____

4. 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**): _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No Yes **If yes,** estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No Yes **If yes,** are the treatments or the reduced number of hours of work medically necessary? 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: _____

Estimate the part-time or reduced work schedule the employee needs, if any: _____ hr(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No Yes Is it medically necessary for the employee to be absent from work during the flare-ups? No Yes. **If yes,** explain: _____

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):

Additional Information: Identify question number with your additional answer. _____

Signature of Health Care Provider

Date