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| **SECTION I: For Completion by the Employee** |

*Please complete Section I before giving this form to your family member or his/her medical provider.*

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| --- | --- | --- | --- | --- | --- |
| Your name: |  |  |  |  |  |
|  | *First* |  | *Middle* |  | *Last* |

**Name of family member for whom you will provide care:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| *First* |  | *Middle* |  | *Last* |

|  |  |
| --- | --- |
| Relationship of family member to you: |  |

|  |  |
| --- | --- |
| If family member is your son or daughter, date of birth: |  |

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

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| --- | --- | --- | --- |
| **Employee Signature** |  | **Date** |  |

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| **SECTION II: For Completion by the Health Care Provider** |

The employee named above has requested leave 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 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 leave. Page 3 provides space for additional detail should you need it.

**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? | | | | Yes  No  If so, dates of admission: | |
| Date(s) you treated the patient for 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 so, state the nature of such treatments and expected duration of treatment: | | | | | |

**2.**

|  |  |
| --- | --- |
| Is the medical condition pregnancy? | Yes  No  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 treatment 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 due to his/her medical condition, including any time for treatment and recovery? | | Yes  No |
| 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: | | |

**5.**

|  |  |
| --- | --- |
| Will the patient require follow-up treatment appointments, 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:

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| --- |
|  |

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 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:

|  |
| --- |
|  |

**7.** 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 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Frequency: |  | times per |  | week(s) |  | months(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 QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider’s name and business address:** | | | |  | | | | |
| **Type of practice/Medical specialty:** | | |  | | | | | |
| **Telephone:** |  | | | | **Fax:** |  | | |
| **Signature of Health Care Provider:** | |  | | | | | **Date:** |  |