

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the 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 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 4 provides space for additional information, should you need it. **Please be sure to sign the form on the last page.**

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 for the 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 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, including any time for treatment and recovery? No ____ Yes ____.

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

During this time, will the 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 schedule 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 the flare-ups and the duration of related incapacity 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 Health Care Provider

Date

Printed Name of Health Care Provider: _____

Type of Practice: _____

Phone Number: _____ Fax Number: _____