

Type of Practice / Medical Specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

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

___ Yes ___ No If yes, provide 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 this condition? ___ Yes ___ No

Was medication, other than over-the-counter medication, prescribed? ___ 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 durations of treatment: _____

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

3. 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: ___ Yes ___ No

If so, 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? ___ Yes ___ No

If so, 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? ___Yes ___No

If so, are the treatments or the reduced number of hours of work medically necessary? ___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: _____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(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? ___ Yes ___ No

Is it medically necessary for the employee to be absent from work during the flare-up? ___Yes ___No

If yes, explain: _____

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 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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

Signature of Health Care Provider

Date