

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

PART A: MEDICAL FACTS

1. Approximate date condition commence: _____

Probable duration of condition: _____

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

____No ____Yes If so, dates of admission: _____

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

During this time, will the patient need care? ____No ____Yes

If so, 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 If so, estimate the hours the patient needs care on an intermittent basis

_____ 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 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 year _____ week(s) _____ month(s)

Duration: _____ hours of _____ 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

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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