

SECTION II: For Completion by the HEALTH CARE PROVIDER

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Healthcare Provider's Name: _____
Healthcare Provider's Address: _____
Type of Practice/Medical Specialty: _____
Phone Number: _____ Fax Number: _____

PART A: MEDICAL FACTS OF PATIENT

Approximate date condition began: _____

Probable duration of condition: _____

Mark as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? NO YES

If yes, list date(s) of admission: _____

Date(s) patient was treated for condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition? NO YES

Will medication, other than over-the-counter medication, prescribed? NO YES

Was the patient referred to other health care provider(s) for evaluation/treatment? (e.g., physical therapist)? NO YES

If yes, state the nature and expected duration of the treatment(s): _____

Is the medical condition pregnancy? NO YES if yes, list the expected delivery date: _____

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.

1. Will the patient be incapacitated for a single continuous period of time, due to his/her medical condition, including time for treatment and recovery? YES NO
 - a. If yes, estimate the beginning and ending dates for the period of incapacity: _____
 - b. During this time, will the patient need care? YES NO
 - c. Explain the care needed by the patient and why the care is medically necessary:

2. Will the patient require follow up treatments, including time for recovery? YES NO
 - a. Estimate treatment schedule including dates of scheduled appointments and the time required for each appointment, including any recovery period: _____

 - b. Explain the care needed by the patient, and why such care is medically necessary: _____

3. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
 YES NO
 - a. Estimate the part-time/reduced work schedule the employee needs while being treated, if applicable:
Date Start and End: _____ Hours per day: _____ Days per week: _____
 - b. Explain the care needed by the patient, and why such care is medically necessary: _____

4. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activity? YES NO
5. 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)
 - a. Frequency of condition: _____
 - b. Duration of each episode (hours to days): _____
 - c. Does the patient need care during these flare-ups? YES NO
 - d. Explain the care needed by the patient, and why such care is medically necessary: _____

Any additional information regarding the patient? _____

Fax to Ken Anderson with Canyons School District – Human Resources at 801-826-5374 when completed and signed.

If you have any questions about the form, contact Kim at kim.mccluskey@canyonsdistrict.org or at 801-826-5452

Healthcare Provider Signature

Date