

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 or treatment? (e.g., physical therapist)?
 NO YES

If yes, state the nature of such treatments and expected duration of treatment: _____

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

Use the information provided by the employer in Section I to answer this question. 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? NO YES

If yes, identify the job functions the employee is unable to perform: _____

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

1. Will the employee 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: _____

2. Will the employee need to attend follow up treatment appointment or work part-time/on a reduced schedule because of the employee's condition? YES NO
 - a. If yes, are the treatments or the reduced number of hours of work medically necessary? Yes No
 - b. If yes, list and estimated treatment schedule, if any, and include the dates of schedule appointments and time request for each appointment/recovery period: _____

 - c. Estimate the part-time/reduced work schedule the employee needs while being treated, if applicable:
_____ Hours per day _____ days per week
Date Time Frame: _____

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job responsibilities? YES NO

4. Is it medically necessary for the employee to be absent from work during the flare ups? YES NO
 - a. If yes, explain: _____

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)

Frequency of condition: _____

ADDITIONAL INFORMATION: *List question number you need to expand upon*

Signature of Health Care Provider

Date

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STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29

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