

SAMPLE FORM

Medical Inquiry RE COVID-19 Request for Leave or Reassignment

Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request by employee for leave/reassignment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Instructions to Health Care Professional Completing This Form:**The employee identified above has requested leave or reassignment from existing job duties on the basis that the employee or a family member is at risk due to COVID-19. We need additional information in order to evaluate that request.Please do not provide any information about the employee’s medical condition (or that of their family member) beyond what is necessary to respond to the questions below. If you determine that the employee has a medical condition that makes them unable to perform one or more of the essential functions of their position in light of the COVID-19 pandemic, or that it would pose a direct threat to the employee or others to do so, please complete the corresponding questions to determine what accommodation, if any, is needed. Please do not provide information relating to any other medical conditions. |

I have reviewed the job description for this employee. He/she: [check all that apply]

|  |
| --- |
| [ ]  is able to perform all essential functions of their position without posing a direct threat to themselves or others  |
| [ ]  is able to perform the essential functions of his/her position with the following restrictions (describe below and complete the attached medical certification for accommodations): |
|  |
|  |
| [ ]  is unable to perform one or more essential functions of the position and should be placed on a leave of absence (complete the attached certifications of health care provider for employee’s serious health condition and medical certification for accommodations) |
| [ ]  is unable to perform one or more essential functions of the position because of the need to care for a family member with a serious health condition (complete attached certification of health care provider for a family member’s serious health condition) |
| [ ]  needs to be reassigned to different work based on a medical condition of the employee or their family member: (describe below and complete the attached medical certification for accommodations) |
|  |
|  |
| [ ]  is pregnant and needs to be placed on leave as a result of pregnancy-related conditions |

|  |  |
| --- | --- |
| **Signature of Health Care Provider (sign and print name):** | **Date**: |
| **Type of Practice:** | **Practice Address:** | **Phone Number (with area code):** |

***Please Note:*** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

MEDICAL CERTIFICATION FOR ACCOMMODATION

Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request by employee for leave/reassignment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructions to Health Care Professional Completing This Form:**

The employee identified above has requested leave or reassignment from existing job duties on the basis that the employee or a family member is at risk due to COVID-19. We need additional information in order to evaluate that request.

**COMPLETE THIS FORM ONLY IF THE EMPLOYEE IS UNABLE TO PERFORM ALL ESSENTIAL JOB FUNCTIONS AS A RESULT OF A MEDICAL CONDITION OR IF DOING SO POSES A DIRECT THREAT TO THE EMPLOYEE OR OTHERS**

If you determine that the employee has a medical condition that makes them unable to safely perform one or more of the essential functions of their position in light of the COVID-19 pandemic, or that it would pose a direct threat to the employee or others to do so, please complete the corresponding questions to determine what accommodation, if any, is needed. Please do not provide information relating to any other medical conditions.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Check any major life activity that is substantially limited by the condition rendering the employee unable perform their job functions: |  |  |
|    |  | Caring for oneself |  | Performing manual tasks |  | Seeing |  |
|  |  | Hearing |  | Eating |  | Sleeping |  |
|  |  | Walking |  | Standing |  | Lifting |  |
|  |  | Bending |  | Speaking |  | Breathing |  |
|  |  | Learning |  | Reading |  | Concentrating |  |
|  |  | Thinking |  | Communicating |  | Working |  |
|  |  | Sitting |  | Reaching |  | Interacting with others |  |
|  |  | Operation of a major bodily function (see below) |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

|  |  |
| --- | --- |
|  | If applicable, check any major bodily function that is substantially limited: |
|  |  | Immune system |  | Special sense organs and skin |  | Normal cell growth |
|  |  | Digestive functions |  | Genitourinary functions |  | Bowel functions |
|  |  | Bladder functions |  | Neurological functions |  | Cardiovascular functions |
|  |  | Endocrine functions |  | Hemic functions |  | Lymphatic functions |
|  |  | Musculoskeletal functions |  | Reproductive functions |  | Operation of an individual organ:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Explain how the individual's impairment substantially limits any major life activity identified above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Information to Determine Need for an Accommodation**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Does this individual have difficulty accessing an employment benefit**?**  | Newcheckmark.png | Yes | Newcheckmark.png | No |  |  |
|  | If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | **What are the essential job functions of your patient's position that he/she is currently able to perform, if any?**  |  |  |  |  |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | **What are the essential job functions of your patient's position that he/she is currently unable to perform, if any**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Please suggest **any possible** workplace accommodation(s) you believe will **assist your patient in performing his/her essential job functions**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | How would any suggested accommodation help this individual perform the individual's job functions or access an employment benefit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Please note the duration of the possible workplace accommodation(s) listed above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

****Please provide any additional information that might be useful in processing this accommodation request, including any potential alternatives to the accommodations suggested above:****

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **Signature of Health Care Provider (sign and print name):** | **Date**: |
| **Type of Practice:** | **Practice Address:** | **Phone Number (with area code):** |

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**Certification of Health Care Provider for**

**Employee’s Serious Health Condition**

**SECTION I: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits EMPLOYER to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by EMPLOYER, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. EMPLOYER must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name:

 First Middle Last

**SECTION II: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to 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.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please be sure to sign the form on the last page.

Health Care Provider’s name and business address:

Type of practice / Medical specialty:

Telephone: ( ) Fax: ( )

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART A: MEDICAL FACTS**

# 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?

\_\_\_\_\_No \_\_\_\_\_Yes. If so, 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 the condition? \_\_\_\_\_No \_\_\_\_\_Yes

Was 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, expected delivery date:

# Use the job description 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**

# 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? \_\_\_\_\_No \_\_\_\_\_Yes

If yes, estimate the beginning and ending dates for the period of incapacity:

# 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? \_\_\_\_\_No \_\_\_\_\_Yes

If yes, are the follow-up treatments or the reduced number of hours of work medically necessary?
 \_\_\_\_\_No \_\_\_\_\_Yes

Estimate the 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 \_\_\_\_\_\_\_\_\_\_

# Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? \_\_\_\_\_No \_\_\_\_\_Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?
 \_\_\_\_\_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 \_\_\_\_\_ 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 (sign and print name):** | **Date**: |
| **Type of Practice:** | **Practice Address:** | **Phone Number (with area code):** |

**Certification of Health Care Provider for**

**Family Member’s Serious Health Condition**

**SECTION I: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits EMPLOYER to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by EMPLOYER, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. EMPLOYER must give you at least 15 calendar days to return this form to EMPLOYER. 29 C.F.R. § 825.305.

Your name:

 First Middle Last

Name of family member for whom you will provide care:

 First Middle Last

Relationship of family member to you:

If family member is your son or daughter, date of birth:

Describe care you will provide to your family member and estimate leave needed to provide care:

Print Name of Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION II: 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.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. However, information about an employee's family member, that may be considered family medical history, may be provided if the employee is requesting FMLA leave to care for that family member with a serious health condition and the information is necessary to determine the employee's eligibility for FMLA leave.

Please be sure to sign the form on the last page.

Provider’s name and business address:

Type of practice / Medical specialty:

Telephone: ( ) Fax: ( )

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART A: MEDICAL FACTS**

# 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 yes, dates of admission:

Date(s) you treated the patient for 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 yes, state the nature of such treatments and expected duration of treatment:

# Is the medical condition pregnancy? \_\_\_\_\_No \_\_\_\_\_Yes

If so, 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.

# 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:

# 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:

# 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:

# 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 six months (*e.g*., one episode every three months lasting one-two 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 (sign and print name):** | **Date**: |
| **Type of Practice:** | **Practice Address:** | **Phone Number (with area code):** |