



**To be completed by health care provider:**

Your patient has requested leave under the FMLA. 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 the 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. Extra space is provided, should you need it. Please be sure to sign the form on the last page.

Providers's name and business address: \_\_\_\_\_  
\_\_\_\_\_

Type of practice/Medical specialty: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax:( \_\_\_\_\_ ) \_\_\_\_\_

**Medical Facts**

1. 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?

Yes  No If yes, dates of admission: \_\_\_\_\_

Dates(s) you treated the patient for condition \_\_\_\_\_

Was medication, other than over-the-counter medication, prescribed?  Yes  No

Will the patient need to have treatment visits at least twice per year due to the condition?

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 duration of treatment:

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

2. Is the medical condition pregnancy?  Yes  No

If yes, expected delivery date: \_\_\_\_\_

3. Use the information provided by the district in the "To be completed by the district" section to answer this question. If the district 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 yes, 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):

---

---

---

**Amount of leave needed**

1. 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 yes, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

---

2. 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 yes, 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 \_\_\_\_\_

3. 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-ups?

Yes  No If yes, explain: \_\_\_\_\_

---

Based upon the employee's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the employee may have over the next six months (e.g. one episode every three months lasting one to two days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**Additional Information – Identify the question number with your additional answer:**

---

---

---

---

---

---

---

Signature of health care provider

Date