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| **PART 1- Employee Information: *To Be Completed by Employee*** | | | | | |
| Employee name: | EID: | | Employee phone: | Employee email: | |
| Employee department: | Family Member’s relationship to you:  If a child, the child’s date of birth: mm/dd/yyyy | | | | |
| Describe the care you will provide an estimate the amount and/or frequency of leave needed:  (Please be as specific as possible regarding your need for leave. Examples: “up to 3 mornings or afternoons per month to take my mother to health care appointments” or “1 week to care for my son following surgery”) | | | | | |
| Employee Signature: Date: mm/dd/yyyy | | | | | |
| **PART 2 – Medical Facts: *To Be Completed by Health Care Provider*** | | | | | |
| **Our employee is requesting leave from work and/or a modified work schedule under the FMLA to care for a family member who is your patient. Please provide the information requested below so that we can process our employee’s leave request. Only provide information regarding the condition(s) that relate to your patient’s need for care from another person.** | | | | | |
| Describe the medical facts related to your patient’s condition(s) that require care from another person (medical facts may include symptoms, diagnosis, or any plan for continuing treatment or therapy) | | | | | |
| Approximate date condition(s) began: mm/dd/yyyy | | Probable duration of condition(s) (days, weeks, months): | | | |
| Was your patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? No Yes  If yes, dates of admission: | | | | | |
| Will your 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 your patient referred to other health care provider(s) for evaluation or treatment? No Yes  If yes, describe the nature and expected duration of the treatments: | | | | | |
| **PART 3 – Requirements for Care: *To Be Completed by Health Care Provider*** | | | | | |
| **We know that health conditions can vary or change over time, so please provide your best estimate in response to these questions, being as specific as you can. Using terms such as “lifetime,” “unknown,” or “as needed” may not be specific enough for us to determine leave eligibility for our employee under the Family and Medical Leave Act. Please consider that your patient’s need for care may include basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.** | | | | | |
| **My Patient Needs:**  **Continuous Care:**  Will your patient be incapacitated for a single, continuous period of time including time for treatment and recovery?  No Yes  If yes, estimate the beginning and ending dates for the period of incapacity: from (date) mm/dd/yyyy to (date) mm/dd/yyyy  During this time, will the patient need care from another person? No Yes  If yes, please explain:      ---------------------------------------------------------------------------------------------------------------------------------------------------------------------  **Intermittent Care:**  Will your patient be incapacitated in a manner that requires intermittent or periodic care due to their medical condition, including  time for treatment and recovery ? No Yes  If yes, please explain:    Based upon your patient’s medical history and your knowledge of the medical condition(s), estimate the frequency of the patient’s  need for intermittent care over the next 6 months (e.g. 1 time per week for 2 days per episode) :  **Frequency:**       time(s) per       week or       month  **Duration:**       hour(s) or       day(s) per episode  Anticipated duration of need (date) mm/dd/yyyy to (date) mm/dd/yyyy  ---------------------------------------------------------------------------------------------------------------------------------------------------------------------  **Appointments:**  Are follow-up treatment appointments medically necessary for your patient and will they need assistance from another person to get  there? No Yes  If yes, please explain frequency:  **Frequency:**       time(s) per       week or       month  From: (Date) mm/dd/yyyy to: (Date) mm/dd/yyyy | | | | | |
| The Genetic Information Nondiscrimination Act of 2008 (GINA):  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. | | | | | |
| **Health Care Provider Information**  Name: (please print)       Specialty:  Business Address:       Phone:    -   - | | | | | |
| Health Care Provider Signature:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: mm/dd/yyyy | | | | | |