



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

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**MEDICAL**

1. 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 so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2. Is the medical condition pregnancy? \_\_\_\_ No \_\_\_\_ Yes. If so, expected delivery date: \_\_\_\_\_

3. Answer the following 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 so, 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**

5. 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

a. If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

b. What is the anticipated return to work date? \_\_\_\_\_

c. If the employee may perform some work, are there any medical restrictions concerning the employee's ability to perform essential job functions? Please clearly describe those restrictions:

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d. How long will the medical restrictions likely last? \_\_\_/\_\_\_/\_\_\_ thru \_\_\_/\_\_\_/\_\_\_.

6. 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 so, are the treatments or the reduced number of hours of work medically necessary? \_\_\_ 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:

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Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

7. 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  
If so, explain:

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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

8. Is the condition due to the employee's occupation? \_\_\_ No \_\_\_ Yes. If yes, please explain:

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**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

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Signature of Health Care Provider

Date

**RETURN COMPLETED FORM TO THE COMPANY MEDICAL FACILITY LISTED ON PAGE ONE.**