
SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLPMSG 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 FMLPMSG coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone:() _____ Fax:() _____

PART A: 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?

___ No ___ Yes. If so, 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

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

3. 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, or the provision of physical or psychological care.

4. Will the patient be incapacitated for one or more continuous periods 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: _____

5. 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: _____

6. 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: _____

7. 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 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

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

Date

PRINTED NAME AND TITLE