

**SECTION I: For completion by the EMPLOYEE and/or the COVERED SERVICE MEMBER
for whom the employee is requesting leave.**

Please complete this section before giving this form to your family member or his/her medical provider.

PART A: EMPLOYEE INFORMATION

Employee's Name (Last, First): _____ Banner ID: 800

Information of family member for whom employee is requesting leave to care:

Name: _____ Relationship: _____

If family member is employee's son or daughter, Date of Birth: _____

Describe care that will be provided to family member by employee and estimate leave needed to provide care:

Employee Signature: _____ Date: _____

SECTION II: For Completion by the HEALTH CARE PROVIDER

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

2. Probable duration of condition: _____

3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes No

If yes; Date(s) of admission: _____ Date(s) of discharge: _____

4. Date(s) patient was seen in your office for condition: _____

5. Medical diagnosis of condition: _____

6. Will the patient need to have treatment visits at least twice per year due to the condition? Yes No

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

If yes, what was prescribed? _____

8. 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: _____

9. Describe relevant medical facts related to the above condition for which the employee seeks leave including symptoms, or any regimen of continuing treatment. _____

PART B: AMOUNT OF LEAVE NEEDED

When answering these questions, keep in mind that your patient's need or care by the employee seeking leave may include assistance with basic medical, hygiene, nutritional, safety or transportation needs, or the provision of physical or psychological care.

10. 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 so, estimate the beginning and ending dates for the period of incapacity: _____

11. During this time, will the patient need care? Yes No

Explain the care needed by the patient and why such care is medically necessary: _____

12. Will the patient require follow-up treatments, including any time for recovery? 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: _____

13. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? Yes No

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: _____

14. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

Yes No

15. Does the patient need care during the flare-ups? Yes No

If so, explain: _____

16. 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 _____ days(s) per episode

PLEASE LIST ANY ADDITIONAL INFORMATION HERE:

Health Care Provider Authorization

Signature of Health Care Provider: _____

Printed Name: _____

Type of Practice: _____

Telephone: _____

Mailing Address: _____

Date: _____

FOR HR OFFICE USE ONLY

H.R. Approval: Yes No Authorized Signature: _____

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.