



<b>Name of Health Care Provider:</b>	<b>Type of Practice / Medical Specialty:</b>
<b>Name of Hospital or Clinic and Business Address:</b>	<b>Phone:</b> <b>Fax:</b> <b>Email Address:</b>

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, included 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." (29 C.F.R 1635.8(b)(1)(i)(B))

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_ Probable duration of condition: \_\_\_\_\_
  - a. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes  No  If so, dates of admission: \_\_\_\_\_
  - b. Date(s) you treated the patient for condition: \_\_\_\_\_
  - c. Will the patient need to have treatment visits at least twice per year due to the condition? Yes  No
  - d. Was medication, other than over-the-counter medication, prescribed? Yes  No
  - e. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes  No  If so, state the nature of such treatments and expected duration of treatment: \_\_\_\_\_
  
2. Is the medical condition a pregnancy? Yes  No  If so, expected delivery date: \_\_\_\_\_
  
3. 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):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PART B: AMOUNT OF CARE NEEDED**

**Instructions to the HEALTH CARE PROVIDER:** 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 needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? Yes  No 
  - a. If so, estimate the beginning and ending dates for the period of incapacity: **Beginning:** \_\_\_\_\_ **Ending:** \_\_\_\_\_
  - b. During this time, will the patient need care? Yes  No
  - c. 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? Yes  No 
  - a. Estimate treatment schedule, if any:
    1. Dates of any scheduled appointments \_\_\_\_\_
    2. Time required for each appointment, including any recovery period: \_\_\_\_\_
  - b. 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? Yes  No 
  - a. Estimate the hours the patient needs care on an intermittent basis, if any:  
 \_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_
  
7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? Yes  No 
  - a. 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 six months (e.g. One episode every three months lasting 1-2 days):  
**Frequency:** \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)  
**Duration:** \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

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

c. Explain the care needed by the patient and why such care is medically necessary: \_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INFORMATION:** Identify the question number with your additional answer(s)

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

<b>Signature of Health Care Provider:</b>	<b>Date:</b>
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**RETURN COMPLETED FORM TO THE PATIENT**

# FMLA Definition of Serious Health Conditions

Based on guidelines from the U.S. Department of Labor

TYPE	QUALIFYING CRITERIA	EXAMPLES
1. Hospitalization and Subsequent Treatment	INCAPACITY* INVOLVING AN OVERNIGHT STAY IN A HOSPITAL OR RESIDENTIAL MEDICAL CARE FACILITY	Hospitalization for surgery Post-surgery doctor's exam Post-surgery physical therapy sessions
2. Pregnancy and Prenatal Care	ANY PERIOD OF INCAPACITY* No other qualifications A doctor's visit during the absence is <i>not</i> required. The employee husband of a pregnant spouse is entitled to FMLA leave to care for the pregnant spouse.	Morning sickness Doctor's visit for prenatal care
3. Chronic Conditions	ANY PERIOD OF INCAPACITY* due to a chronic condition which:  1. Requires visits for treatment by a health care provider at least twice a year  2. Continues over an extended period of time (including recurring episodes of a condition)  3. May cause episodic rather than continuous incapacity  A doctor's visit during each absence is <i>not</i> required.	Asthma, diabetes, epilepsy, migraine headaches
4. Conditions Requiring Multiple Treatments	ANY PERIOD OF INCAPACITY* for restorative surgery or for conditions that if left untreated would result in incapacity of more than 3 consecutive calendar days.	Chemotherapy or radiation for cancer Dialysis for kidney disease Physical therapy for arthritis
5. Permanent/Long Term Conditions	ANY PERIOD OF INCAPACITY*. Individual must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider.	Alzheimer's, stroke, terminal diseases
6. Other Health Conditions	INCAPACITY* MUST BE FOR MORE THAN 3 CONSECUTIVE CALENDAR DAYS <b>AND</b> 1. Involves treatment 2 or more times by a health care provider and the 2 visits must occur within 30 days of the period of incapacity. The first visit must occur within 7 days of onset of incapacity. <b>OR</b> 2. Involves treatment 1 time by a health care provider followed by a continuing regimen of treatment.	(Not <i>normally</i> included: common cold, flu, earache, routine dental problems) Physical therapy sessions ordered by a doctor for a broken leg A visit to doctor followed by course of prescription antibiotics

\* **Incapacity** – Inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.