Family Medical Leave Act (FMLA) Application Form for a Family Member's Health Condition

To be completed by you and a licensed health care provider describing the family member's medical condition for the purpose of determining eligibility for leave under the Family Medical Leave Act.

TO BE COMPLETED BY EMPLOYEE

First Name: _____ Middle Initial: _____ Last Name: _____

Name of the family member for whom you will provide care:

First Name: _____ Middle Initial: _____ Last Name: _____

Relationship of family member to you: _____

If the family member is your son or daughter, date of birth: _____

Describe the care you will provide to your family member and estimate the leave needed:

Instructions for the Health Care Provider

The employee listed above is requesting leave under the Family Medical Leave Act to care for your patient. Please answer, fully and completely all applicable parts of this form. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. When applicable, circle YES or NO to indicate your response.

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Provider's Name: _____

Type of Practice/Medical Specialty: _____

Telephone: (____) _____ Fax: (____) _____

When did the medical condition(s) begin?

How long is the condition expected to last? If the condition is permanent, please indicate.

Was the patient admitted for an overnight stay in a hospital or residential medical care facility? If yes, what were the dates of admission?

What were the dates in which you treated the patient for this condition?

Will the patient require treatment at least twice per year due to the condition? YES or NO

Was medication, other than over-the-counter medication prescribed? YES or NO

Was the patient referred to other health care providers for evaluation or treatment? If yes, please state the nature of the treatments and expected duration of treatment.

Is the medical condition pregnancy? YES or NO If yes, expected delivery date: _____

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave.

Will the patient be incapacitated for a single continuous period of time due to this condition, including any time for treatment and recovery? YES or NO

If yes, estimate the beginning and ending dates for the period of incapacity:

Will the patient require follow-up treatment appointments because of the condition? YES or NO If yes, are the treatments medically necessary? YES or NO

Please list the estimated treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Will the condition cause episodic flare-ups periodically preventing the employee from performing their essential job functions? YES or NO

Is it medically necessary for the patient to receive care during the flare-ups? YES or NO
If yes, please explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of the 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: _____ weeks/months for: _____ hours or _____ days per episode.

Signature of Health Care Provider: _____ Date: _____

When completed please fax this form to (847) 949-4756, with CONFIDENTIAL: ATTN D120 HR on the cover page.