

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 needs, or the provision of physical or psychological care:

1. A). Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?
___No ___Yes. If yes, please complete sections #2 and #6.

B). Will the patient require follow-up treatments, including any time for recovery?
___No ___Yes. If yes, please complete sections #3 and #6.

C). Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
___No ___Yes. If yes, please complete sections #4 and #6.

D). Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___No ___Yes. If yes, please complete sections #5 and #6

2. Estimate the beginning and ending dates for the period of incapacity: _____

3. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

4. Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

5. 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.

6. Explain the care needed by the patient, and why such care is medically necessary:

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

Signature of Health Care Provider

Date