CONFIDENTIAL MEDICAL DOCUMENTATION

Instructions for Physician:

☐ **Stamp with physician/office stamp OR use a physician letterhead.** This is required.

☐ Provide information legibly and clearly in layman's terms (avoid technical jargon). Include much detail as possible.

Patient's Name**:** _____

Part 1 – Current Evaluation, Analysis and Treatment

- Describe patient's functional restrictions that prevent him/her from being transported to work or performing the duties of his/her job during the timeframe below. If for care of a family member, describe care needed that necessitates employee time-off work for the timeframe below**:**

- Nature of medical condition:

- Anticipated duration of medical condition (***IMPORTANT:*** Specify start and end dates):

- If medical condition is intermittent, describe duration and frequency (***IMPORTANT***: Specify number of hours/days per day, per week, or per month).

- ICD-10 and/or ICD-9 Diagnosis/Procedure Codes:

Part II– Certification

I certify that the absence or treatment noted above is necessary to return the patient to a healthy condition or to accommodate his/her medical condition. **The patient is unable to work, because of the reasons stated in Part I of this application**. This certification may also apply to caring for a family member. An appropriate family member may apply on behalf of an incapacitated family member.

_____

Physician's Name (Signature) Date

_____

Physician's Name (Typed or Printed) Specialty Title

_____

Physician's Address Phone Number