For Completion by the HEALTH CARE PROVIDER for Catastrophic Leave Bank Application

Instructions to the HEALTH CARE PROVIDER: The employee listed above has requested catastrophic leave for their own serious health condition or to care for your patient. Please answer fully and completely, all applicable parts below. Several questions seek a response as to frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience, and examination of the patient. Terms such as "unknown" or "indeterminate" may not be sufficient to determine a need for leave. Page 2 provides space for additional information. Please sign the form on Page 2.

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.

Provider Name and Business Address:

Telephone#: Fax#:

Type of Practice/Medical Specialty:

Patient Name:

1. Diagnosis: Please include primary and list secondary conditions.

2. If pregnancy, state estimated due date:

3. Approximate date condition commenced:

4. Is the condition ☐ Emergent? ☐ Urgent? ☐ Elective?

5. Date first unable to work:

6. Date of first visit for this illness/injury: When did recent symptoms first appear or accident happen?

7. Was the patient admitted to a hospital, hospice or residential medical care facility? ☐ Yes ☐ No
   If yes, please provide dates of admission/discharge.

8. Which medications, other than OTC, prescribed?

9. Nature of treatment(s) (include surgical procedure)

10. Was the patient referred to other health care provider(s) for evaluation or treatment? ☐ Yes ☐ No
    If yes, state the nature of such treatments ad expected durations of treatment.

11. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
    ☐ Yes ☐ No If yes, estimate the hours needed on an intermittent basis.

Hours per day: _____ Days per week_____ From through

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

13. Has the patient been released to work in his/her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No

If no, when should the patient return to work? Full time Part Time

Additional Information: Use back if necessary.

Signature of Healthcare Provider	Date