



Employee Sick Leave Donation Medical documentation (non-FMLA)

Employee Name

Telephone number

Email address:

Street address

City

Zip

- (1) State the approximate date the condition started or will start:
- (2) Provide your best estimate of how long the condition lasted or will last:
- (3) Check the box(es) for the questions below, as applicable.

Inpatient Care: The patient (has been is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

Incapacity plus Treatment: (e.g. outpatient surgery, strep throat) Due to the condition, the patient (has been is expected to be) incapacitated for more than three consecutive, full calendar days from: to . The patient (was will be) seen on the following date(s):

The condition (has has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

Pregnancy: The condition is pregnancy. List the expected delivery date:

Chronic Conditions: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

Permanent or Long Term Conditions: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

Conditions requiring Multiple Treatments: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

None of the above: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed.

- (4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks medical leave.

Complete all that apply:

(5) Due to the condition, the patient (had will have) planned medical treatment(s) (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s):

(6) Due to the condition, the patient (was will be) referred to other health care provider(s) for evaluation or treatment(s). State the nature of such treatments: (e.g. cardiologist, physical therapy) Provide your best estimate of the beginning date and end date for the treatment(s). Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

(7) Due to the condition, it is medically necessary for the employee to work a reduced schedule. Provide your best estimate of the reduced schedule the employee is able to work. From to the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

(8) Due to the condition, the patient (for treatment(s) and/or recovery was will be) incapacitated for a continuous period of time, including any time Provide your best estimate of the beginning date and end date for the period of incapacity.

(9) Due to the condition, it (was is will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last. Over the next 6 months, episodes of incapacity are estimated to occur times per (day(s) week month) and are likely to last approximately hours days) per episode.

Health Care Provider's name: (Print)

Health Care Provider's business address:

Type of practice / Medical specialty:

Telephone:

E-mail:

Date

Genetic Information Nondiscrimination Act of 2008 (GINA) Disclosure Statement

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. 29 U.S.C. § 1635.8(b).