

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Part B: Amount of Leave Needed

4. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? YES NO

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

Is the employee able to work while incapacitated?

YES NO _____

5. Will the patient need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? YES NO

If so, are the treatments or the reduced number of hours of work medically necessary? YES NO

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

Estimate the part-time or reduced work schedule (e.g. hour(s) per day, day(s) per week, and from and through dates) the employee needs, if any:

6. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? YES NO

Is it medically necessary for the employee to be absent from work during the flare-ups? YES NO

If so, explain: _____

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

Signature of Health Care Provider

Date

Return To:
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