SECTION I - EMPLOYER		
SECTION 1 - EMPLOTER		
SECTION II		

Employee Name:				
(3) Briefly describe the care you	will provide to your family m	ember: (Check all tha	t apply)	
Assistance with bas	sic medical, hygienic, nutrition	onal, or safety needs	Transportation	
Physical Care	Psychological Comfo	ort Other:		
(4) Give your best estimate of the	ne amount of leave needed t	o provide the care des	cribed:	
	is necessary to provide the		our best estimate of the reduced so (mm/dd/yyyy), I am able to	
(hours per day)	(days per wee	k)		
Employee Signature			Date	(mm/dd/yyyy)
SECTION III - HEALTH CAR	E PROVIDER			
Please provide your contact info			on, and sign the form below. A fami	ly member of your patient
	• • • • • • • • • • • • • • • • • • • •			

Empic	yee Name:									
(5) Ch	eck the box(es) f	or the q	uestions b	oelow, as applica	able. For all box(e	s) checked, the	e amount of leav	ve needed mus	t be provided in	Part B.
	Inpatient Care	: The pa	itient (has been /	is expected to be	e) (yto7 (ti)-6fo	Γd[rJ1((e)9 to7	(ti)-6tm)t)e (9 (s)7 (ti)-6p d)-4 0) Td h
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Employee Name:							
(9) Due to the condition, the patient (was / will be) incapacitated for a continuous period of time , including any time for treatment(s) and/or recovery.							
Provide your best estimate of the beginning date for the period of incapacity.	_ (mm/dd/yyyy) and end date	(mm/dd/yyyy).					
(10) Due to the condition, it (was / is / will be) medically provide care for the patient on an intermittent basis (per to dically), including							