

Employee Name:	
Health Care Provider's name: (Print)	
Health Care Provider's business address:	
Type of practice / Medical specialty:	
Telephone: () Fax: () E-mail:	
PART A: Medical Information  Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(e)cM22F6629.79(29035MB2Ma)(e)cM22F6629.79(e)cM	184
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