

SECTION 1 – EMPLOYEE INFORMATION

Employee Name:		Badge # or "C" #:	Six-Digit I.D. #:
Emp. Contact Phone:	Job Title:	Work Group:	Base Location:
Employee Mailing Address:		Employee Email Address:	

Authorization to Release Medical Information: I hereby authorize a health care provider representing US Airways to contact the undersigned health care provider for purposes of clarification. Also, I understand that any resulting fees are my responsibility.

Employee Signature: _____

SECTION 2 – CARE FOR FAMILY MEMBER

A. Complete patient information below if Employee is not the patient.
 See FML Policy on WINGS for more information on domestic partners and birth/adoption/foster care. You are required to provide certification of birth, adoption, or placement.

Patient Name if Not Employee:	Relationship to Employee:	Patient Date of Birth:
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Patient Requires Employee's Assistance For:
 Basic Medical Personal Needs Psychological Comfort Safety Transportation
 Other: _____

B. Employee Statement (To be completed by employee.)
 State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

Sections 3 through 7 MUST be completed by the Health Care Provider if this application is to be considered complete.

SECTION 3A – SERIOUS HEALTH CONDITION

Choose One	Requirements
<input type="checkbox"/> Inpatient Care Admission Date _____ Release Date _____	An overnight stay in a hospital, residential treatment facility, or hospice
<input type="checkbox"/> Pregnancy Estimated Due Date _____	Birth of child or inability to work due to pregnancy or pre-natal care
<input type="checkbox"/> Absence to Receive Multiple Treatments	Restorative surgery after an accident/injury or treatment for a condition that would prevent patient from working more than three consecutive days if not treated
<input type="checkbox"/> Permanent or Long Term Incapacity	Extended inability to work due to a condition for which treatment may not be effective and patient is under your continuing supervision
<input type="checkbox"/> Chronic Condition NOTE: See requirements to the right →	Condition requires periodic visits (at least twice per year) for treatment and continues over an extended period of time, and may cause episodic periods of inability to work rather than a continuing period of incapacity. <input type="checkbox"/> Patient will be seen at least twice per year for their Serious Health Condition. Must list approximate dates in Section 5 on Page 2.
<input type="checkbox"/> Absence Plus Continuing Treatment Consecutive Dates of Inability to Work Start Date _____ End Date _____	Inability to work for more than three consecutive days, treatment on two or more occasions, or treatment on one occasion that results in a regimen of continuing treatment
<input type="checkbox"/> None of the above definitions apply to this patient.	

Sections 3 through 7 MUST be completed by the Health Care Provider if this application is to be considered complete.

**SECTION 3B – EMPLOYEE SERIOUS HEALTH CONDITION DETAILS (EMPLOYEE ONLY)
SEE SECTION 4 FOR CAREGIVER**

NOTE: A SEPARATE FORM MUST BE USED FOR EACH SERIOUS HEALTH CONDITION.

Describe the relevant medical facts that support the Serious Health Condition Type selected in Section 3 that are related to the condition for which the employee seeks leave (such medical facts may include symptoms and diagnosis).

NOTE: This section is optional for California employees. Do not disclose the underlying diagnosis on this form without the consent of the patient.

Most Recent Date you treated the Patient for this Specific Condition

Probable Duration of the Serious Health Condition

Probable Duration of Patient's Present Inability to Work

List Restrictions and Work Functions the employee is unable to perform when incapacitated. (A description of the essential job functions for the employee is available.)

How Does the Serious Health Condition Prevent the Patient from Working?

SECTION 4 – NON-EMPLOYEE SERIOUS HEALTH CONDITION DETAILS (NON-EMPLOYEE ONLY)

NOTE: A SEPARATE FORM MUST BE USED FOR EACH SERIOUS HEALTH CONDITION.

Describe the relevant medical facts that support the Serious Health Condition Type selected in Section 3A that are related to the condition for which the employee seeks leave (such medical facts may include symptoms and diagnosis).

Most Recent Date you treated the Patient for this Specific Condition

Probable Duration of the Serious Health Condition

Describe the care the employee needs to provide for your patient's basic medical needs and why it is medically necessary.

For care of a dependent child 18 or older with physical/mental impairment that substantially limits one or more major life activities, please list the activities of daily living the child is unable to perform.

Can the employee provide this care outside of their work hours? Yes No If No, please explain.
Details

Next Appointment Date

