

Section 1 is to be completed by the employee.

If you include your e-mail address, all correspondence related to your leave request will be sent here, not via US Mail.

Family Medical Leave Health Care Provider Form

SECTION 1 - EMPLOYEE INFORMATION

Employee Name:	Job Title:	Five-Digit I.D. #:	Six-Digit I.D. #:
Employee Contact Phone:	Base Location:	Manager Name:	
Employee Mailing Address:		Employee Email Address:	
If you provide an e-mail address, all correspondence related to your leave will be sent to you via e-mail.			

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.

If you are applying to be Caregiver to a qualified family member, complete all of Section 2.

Sections 3 through 6 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	Condition requires periodic visits (at least twice per year) for treatment, or 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"/> 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.	

All of Section 3A is to be completed by the treating health care provider.

If applying to be a Caregiver, **THE FAMILY MEMBER'S** health care provider is to complete Sections 3A, 3B, 4, 5, and 6.

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

If the patient has more than one Serious Health Condition, a separate set of paperwork must be completed for each.

Section 3B must be completed by the treating health care provider. All questions must be answered.

The treating health care provider MUST select one type of leave for the patient and answer all questions in that selection.

Sections 3 through 6 MUST be completed by the Health Care Provider if this application is to be considered complete.

SECTION 3B – SERIOUS HEALTH CONDITION DETAILS

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).

Date Serious Health Condition Began	Probable Duration of the Serious Health Condition
Probable Duration of Patient's Present Inability to Work	List Any Restrictions
How Does the Serious Health Condition Prevent the Patient from Working?	

SECTION 4 – LEAVE DETAILS

Enter the START and END dates of the appropriate type of leave. Fill in columns corresponding to the type of leave that your patient's condition indicates.

Block FML	Intermittent FML	Reduced-Schedule FML
Block leave is indicated when the employee is incapacitated and requires a single consecutive block of time away from work due to the serious health condition.	Intermittent FML for self or caregiver is indicated when episodic flare-ups periodically prevent the employee from performing his/her job functions.	Reduced-Schedule FML is indicated when the employee requires a reduced number of hours/ days of daily work due to the serious health condition.
Dates of incapacity are: Start Date _____ End Date _____ Re-evaluation Date _____ Employee Return to Work Date _____	Is it medically necessary for the employee to be absent from work during the flare-ups? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____ Start Date _____ End Date _____ Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of the related incapacity that the patient may have (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	Start Date _____ End Date _____ Approximately how many Hours per day/Day per week should the employee work? _____ HOURS PER DAY _____ DAYS PER WEEK Re-evaluation Date _____ NOTE: This leave option does not apply to Flight Crew Members.

Frequency and Duration questions must be answered in a numeric term. Words such as "undetermined," "indefinite," etc., will not be accepted.

If the treating health care provider selects one of the Absence Plus Treatment conditions in Section 3A, they must complete all of Section 5.

SECTION 5 – TREATMENTS

Will the patient need to have treatment visits at least twice per year due to the condition? Yes No

Was medication, other than over-the-counter medication, prescribed? Yes No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes No

If so, state the nature of such treatments and expected duration of treatment: _____

Will the patient need to attend follow-up treatment appointments? Yes No

If so, are the treatments medically necessary? Yes No

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

SECTION 6 – TREATING HEALTH CARE PROVIDER DETAILS

Health Care Provider's Name (PRINT) _____

Today's Date	Type of Practice	State (location) of Practice
Office Phone #	Office Fax	
Treating Health Care Provider's Signature		

The treating health care provider must complete all of Section 6 for this certification to be valid.