## *Please type or print clearly. To be completed only by physician or his/her designated staff member*

Employee's Name:	LAST	FIRST	MIDDLE	
Family Member/Patient's Name:	LASI	LIV21	MIDDLE	
	LAST	FIRST	MIDDLE	
Relationship of Family Member to I	Employee:			
If Family Member is employee's so	n or daughter, date	e of birth:		
INSTRUCTIONS to the HEALTH CA	RE PROVIDER: The	e employee listed above has reque	ested leave under the FMI	A to care for your
patient. Answer, fully and complet	ely, all applicable	parts. Several questions seek a re	sponse as to the frequence	cy or duration of a
condition, treatment, etc. Your a	nswer should be	your best estimate based upon	your medical knowledge	e, experience, and
examination of the patient. Be as s	pecific as you can;	terms such as "lifetime," "unknow	n," or "indeterminate" ma	ay not be sufficient
to determine FMLA coverage. <b>Plea</b> s	se be sure to sign a	and date this form.		
Provider's name (please print):				
Provider's business address:				
Type of practice / Medical specialty	/:			
Telephone: ()		Fax: ()		
Probable duration of condition:		hospital, hospice, or residential mo		
Date(s) you treated the patient for	or condition:			
Is surgery required?				NoYes
If so, date and type of surgery:				
Will the patient need to have tre	atment visits at lea	st twice per year due to the condit	tion?	NoYes
Was medication, other than over	-the-counter medi	cation, prescribed?		NoYes
Was the patient referred to other If so, state the nature of such tre		er(s) for evaluation or treatment (e ted duration of treatment:	.g., physical therapist)?	NoYes

2. Describe other relevant medical facts related to the condition for which the patient needs care. Such medical facts may include symptoms, detailed treatment plan, or any regimen of continuing treatment (such as the use of specialized equipment):

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ent and recovery?	

		e, including any time for treatment and recovery?	
NoYes		ding dates for the period of incapacity:	
During this time, will the patie	nt need care? • patient and why such care is medically	No	_ Yes
	patient and why such care is medically		
	-up treatments, including any time for r , if any, including the dates of any	recovery?No scheduled appointments and the time required for	
appointment, including any red	covery period.		
	n an intermittent or reduced schedule k t needs care on an intermittent basis, if		_Yes
hour(s) per day; _	days per week from	through	
Explain the care needed by th	e patient, and why such care is medical	y necessary:	
Based upon the patient's med	ical history and your knowledge of the	e patient from participating in normal daily activities? No medical condition, estimate the frequency of flare-ups a e next 6 months (e.g., 1 episode every 3 months lasting f	and
•	week(s) month(s) ring these flare-ups? No Yes e patient, and why such care is medicall	Duration: hours or day(s) per epiny necessary:	sode
7. Employee's anticipated date o	f return to work:		
Signature of Health Care Prov	ider	Date Signed	

This form may be faxed (813-794-2078) or emailed (<u>myleaves@pasco.k12.fl.us</u>) to the Office for Human Resources and Educator Quality (HREQ), Leaves Administration Section. It must have a cover sheet indicating it originates directly from the physician's office.