

REQUEST FOR FAMILY MEDICAL LEAVE FOR **EMPLOYEE**

For Completion by the **EMPLOYEE (PLEASE PRINT)**

Application Date: _____

Name: _____ Last 4 SS#: _____

Home Address: _____ City: _____ Zip: _____

Employee's Email Address: _____

Contact Number: Work: _____ Home/Cell: _____

Job Title: _____ Department: _____

Immediate Supervisor: _____

Do you have a spouse employed by the City? _____ If so, Name and Department: _____

Use of Sick Leave:

Retain _____ hours of sick leave (up to maximum of 80 hours)

ADDITIONAL INFORMATION:

Employee Signature

Date

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

3. Is the employee unable to perform any of his/her job functions due to the condition? **Please complete page 4, (Work Status form) in response to this question.**

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___ No ___ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ No ___ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___ No ___ Yes.

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

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ___ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ___ Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date



FMLA WORK STATUS REPORT

PART I: GENERAL INFORMATION		5. Doctor's Name and Degree	(for transmission purposes only)	Date Being Sent
1. Employee's Name		6. Clinic/Facility Name		9. Employer's Name City of Wichita / City Hall
2. Date of Injury/Illness	3. Social Security Number	7. Clinic/Facility/Doctor Phone & Fax		10. City of Wichita's Fax #
4. Employee's Description of Injury/Illness		8. Clinic/Facility/Doctor Address (street address)		11. Human Resources Office Phone #
		City	State	Zip

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION AS APPLICABLE)

13. The employee's serious health condition:

(a) will allow the employee **to return to work** as of _____ (date) **without restrictions**.

(b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

(c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date). The following describes how this injury **prevents the employee from returning to work**:

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

<p>14. POSTURE RESTRICTIONS (if any):</p> <p>Max Hours per day: 0 2 4 6 8 Other</p> <p>Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Kneeling/Squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Bending/Stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Pushing/Pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p>	<p>17. MOTION RESTRICTIONS (if any):</p> <p>Max Hours per day: 0 2 4 6 8 Other</p> <p>Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Climbing stairs/ladders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Grasping/Squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Wrist flexion/extension <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Overhead Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Keyboarding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p>	<p>19. MISC. RESTRICTIONS (if any):</p> <p><input type="checkbox"/> Max hours per day of work: _____</p> <p><input type="checkbox"/> Sit/Stretch breaks of _____ per _____</p> <p><input type="checkbox"/> Must wear splint/cast at work</p> <p><input type="checkbox"/> Must use crutches at all times</p> <p><input type="checkbox"/> No driving/operating heavy equipment</p> <p><input type="checkbox"/> Can only drive automatic transmission</p> <p><input type="checkbox"/> No work / <input type="checkbox"/> _____ hours/day work: <input type="checkbox"/> in extreme hot/cold environments <input type="checkbox"/> at heights or on scaffolding</p> <p><input type="checkbox"/> Must keep _____: <input type="checkbox"/> Elevated <input type="checkbox"/> Clean & Dry</p> <p><input type="checkbox"/> No skin contact with: _____</p> <p><input type="checkbox"/> Dressing changes necessary at work</p> <p><input type="checkbox"/> No Running</p>
<p>15. RESTRICTIONS SPECIFIC TO (if applicable):</p> <p><input type="checkbox"/> L Hand/Wrist <input type="checkbox"/> R Hand/Wrist</p> <p><input type="checkbox"/> L Arm <input type="checkbox"/> R Arm <input type="checkbox"/> Neck</p> <p><input type="checkbox"/> L Leg <input type="checkbox"/> R Leg <input type="checkbox"/> Back</p> <p><input type="checkbox"/> L Foot/Ankle <input type="checkbox"/> R Foot/Ankle</p> <p><input type="checkbox"/> Other: _____</p>	<p>18. LIFT/CARRY RESTRICTIONS (if any):</p> <p><input type="checkbox"/> May not lift/carry objects more than ____ lbs. for more than ____ hours per day</p> <p><input type="checkbox"/> May not perform any lifting/carrying</p> <p><input type="checkbox"/> Other: _____</p>	<p>20. MEDICATION RESTRICTIONS (if any):</p> <p><input type="checkbox"/> Must take prescription medication(s)</p> <p><input type="checkbox"/> Advised to take over-the-counter meds</p> <p><input type="checkbox"/> Medication may make drowsy (possible Safety/driving issues)</p>
<p>16. OTHER RESTRICTIONS (if any):</p> <hr/> <hr/> <p><small>* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.</small></p>		

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

<p>21. Diagnosis Information:</p> <hr/> <hr/>	<p>22. Expected Follow-up Services Include:</p> <p><input type="checkbox"/> Evaluation by the treating doctor on _____ (date) at ____ : ____ am/pm</p> <p><input type="checkbox"/> Referral to/Consult with _____ on _____ (date) at ____ : ____ am/pm</p> <p><input type="checkbox"/> Physical medicine __ X per week for __ weeks starting on _____ (date) at ____ : ____ am/pm</p> <p><input type="checkbox"/> Special studies (list): _____ on _____ (date) at ____ : ____ am/pm</p> <p><input type="checkbox"/> None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.</p>		
<p>Date of Visit</p> <hr/> <p>Time of Visit</p> <hr/>	<p>DOCTOR'S SIGNATURE</p> <hr/>	<p>Visit Type:</p> <p><input type="checkbox"/> Initial</p> <p><input type="checkbox"/> Follow-up</p>	<p>Role of Doctor:</p> <p><input type="checkbox"/> Designated doctor <input type="checkbox"/> Treating doctor</p> <p><input type="checkbox"/> Carrier-selected RME <input type="checkbox"/> Referral doctor</p> <p><input type="checkbox"/> DWC-selected RME <input type="checkbox"/> Other doctor</p>