OCCUPATIONAL HEALTH & WELL-BEING SERVICES

Your patient, _______________________, is a family member of ______________________, who has requested paid leave under our Temporary Medical Leave Assistance Program (TMLAP). TMLAP is intended to provide employees with paid leave during a family member's acute medical or psychological emergency. **In order to determine how much leave is warranted, information regarding their condition is needed.** Your responses to the following would be greatly appreciated. Thank you in advance for your assistance.

1. What is the medical event (acute diagnosis and ICD) incapacitating your patient? When did it begin?

2. Does your patient need full-time care at this time?

   Yes, full-time care is currently needed

   No, the full-time care is not currently needed

3. If yes, what specific symptoms or limitations does the patient have that require assistance? In other words, what care is the family member providing (e.g., administering medications, helping with ADLs, etc.)?

4. How often and for long does the family member need to be available to assist with the aforementioned care? In other words, how often or for long should they be away from work?

5. What is the evaluation and treatment plan? If known, please include dates of planned diagnostics or procedures.

6. What is the prognosis with regards to symptoms and limitations? If that is unknown, what is a reasonable amount of time until re-evaluation?

Physician/Provider Printed Name: ____

Physician/Provider Signature: _______________________________________ Date: _________________

TMLAP Contact Information: Phone - 240-373-3711; Fax - 443-479-3325