OCCUPATIONAL HEALTH & WELL-BEING SERVICES

Your patient, _____, has requested paid leave under our Temporary Medical Leave Assistance Program (TMLAP). TMLAP is intended to provide employees with paid leave during an 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 acute DSM-5-TR/ICD-11 condition(s) that is incapacitating your patient?

2. What are the current symptoms and limitations caused by each condition listed above? How long has each persisted?

3. What is the evaluation and treatment plan? If known, please include current medication and treatment for the condition(s).

4. What are the recommended occupational restrictions in activity or accommodations?

5. What is the prognosis with respect to the reported symptoms, limitations, and restrictions?

6. When is the patient anticipated to be able to return to work? If that is unknown, what is a reasonable amount of time until re-evaluation?

Physician/Provider Printed Name: _____

Physician/Provider Signature: _____ Date: _____