FMLA Medical Assessment

Service Request

Employee Full name _____ Maiden Name _____

Last First Initial

D.O.B. / / SS# - - Sex: M / F Telephone ( ) -

Address _____

Street

City State Zip

Job Title _____ Department _____

Evaluation type(s)

■ 2nd Opinion ■ 3rd Opinion ■ Status

■ Fitness for Duty ■ Re-Certification

Attending Physician	2nd Attending Physician
Specialty Telephone ( ) -	Specialty Telephone ( ) -
Address	Address
Street	Street
City State ZIP	City State ZIP

Type of Leave:

■ Own Serious Health Condition
■ Care for Child with Serious Health Conditon
■ Care for Spouse with Serious Health Conditon
■ Care for Parent with Serious Health Condition
■ For the birth and care of a newborn child
■ Placement of a child to Foster Care
■ Placement of a child for Adoption
■ Parental Care

Employee Information:

Date of Hire _____
Last Day Worked _____
Leave Start Date _____
Date Leave Requested _____

STD Eligible yes no
LTD Eligible yes no
State Disability yes no

Has employee worked 1,250 hours in the last 12 months? yes no

Attached documents: ■ medical release ■ Attendace Records ■ Job Description

Requestor Information:

Name: Company: _____

Address: _____

Telephone: email: _____

Date Submitted: _____