







**Employee Name:** \_\_\_\_\_

- (9) Due to the condition, the patient ( was / will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

- (10) Due to the condition it, ( was / is / will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per ( day / week / month) and are likely to last approximately \_\_\_\_\_ ( hours / days) per episode.

**Signature of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_ (mm/dd/yyyy)

| Definitions |
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