

QUESTIONNAIRE - FMLA, SHORT-TERM AND LONG-TERM DISABILITY FORMS

Please fill out the following questions and be as specific as possible. Use additional paper if needed.

- 1) Does the medical condition involve you or a family member? If pertaining to a family member, provide their name and primary care provider.

- 2) Describe the medical facts, including specific diagnosis, symptoms, and regimen of continuing treatment for the serious medical condition. BE SPECIFIC.

- 3) Name of the physician and date of the first office visit for this serious medical condition(s):

PHYSICIAN: _____ DATE OF INITIAL DIAGNOSIS: _____

- 4) Names of the physicians and dates of all visits, treatments, hospitalization, for the serious medical condition:

5) Dates of work missed due to incapacity of the serious medical condition:

6) Explain your job duties and responsibilities and why you cannot work. If applicable, give explanations of how treatment and/or medication for your serious condition impact your ability to work as well.

7) When do you anticipate returning to work full time?

8) If you are returning to work with "restrictions" or "limited" to perform your regular duties, please explain in detail why you cannot perform those "limited" duties.
