

TREATMENT PRESCRIBED

Please describe the nature and duration of treatment, including the number and schedule of visits or treatments:

PLEASE RESPOND TO THE FOLLOWING QUESTIONS

	Yes	No
Is in-patient hospitalization of the patient required?	<input type="checkbox"/>	<input type="checkbox"/>
Does (or will) the patient require assistance for basic medical care, hygiene, nutritional needs, safety or transportation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you believe the employee's presence is necessary or would be beneficial for the physical care or psychological comfort of the patient?	<input type="checkbox"/>	<input type="checkbox"/>

Please estimate the number of days per month the employee's presence would be beneficial if this request is for intermittent leave. _____

HEALTH CARE PROVIDER INFORMATION

Name and Address of Health Care Provider: _____

Telephone: _____ FAX: _____

Name of Physician or Practitioner: _____

Field of Specialization (if applicable): _____

Signature of Physician or Practitioner: _____

Please return form to: CONFIDENTIAL-BENEFITS
HUMAN RESOURCES DEPARTMENT
210 MARTIN LUTHER KING JR BLVD RM 501
MADISON WI 53703
FAX 608-267-1115