

**SECTION 1 – EMPLOYEE INFORMATION**

Employee Name:	Job Title:	Payroll I.D. #:	Badge #: (begins with 2)
Employee Contact Phone:	Dept. Name:	Base Location:	Manager Name:
Employee Mailing Address:		Full Time: <input type="checkbox"/>	Part Time: <input type="checkbox"/>
If you provide an e-mail address, all correspondence related to your leave will be sent to you via e-mail.		Employee E-mail Address:	

**Authorization to Release Medical Information:** I hereby authorize a health care provider representing US Airways to contact the undersigned health care provider for purposes of clarification. Also, I understand that any resulting fees are my responsibility.

Employee Signature: \_\_\_\_\_

**SECTION 2 – CARE FOR FAMILY MEMBER**

**A. Complete patient information below if Employee is not the patient.**  
See FML Policy on WINGS for more information on domestic partners and birth/adoption/foster care. You are required to provide certification of birth, adoption, or placement.

Patient Name if Not Employee:	Relationship to Employee:	Patient Date of Birth:
Patient Requires Employee's Assistance For: <input type="checkbox"/> Basic Medical <input type="checkbox"/> Personal Needs <input type="checkbox"/> Psychological Comfort <input type="checkbox"/> Safety <input type="checkbox"/> Transportation <input type="checkbox"/> Other: _____		

**B. Employee Statement** (To be completed by employee.)  
State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

\_\_\_\_\_

\_\_\_\_\_

**Sections 3 through 7 MUST be completed by the Health Care Provider if this application is to be considered complete.**

**SECTION 3A – SERIOUS HEALTH CONDITION**

<b>Choose One</b>	<b>Requirements</b>
<input type="checkbox"/> Inpatient Care Admission Date _____ Release Date _____	An overnight stay in a hospital, residential treatment facility, or hospice
<input type="checkbox"/> Pregnancy Estimated Due Date _____	Birth of child or inability to work due to pregnancy or pre-natal care
<input type="checkbox"/> Absence to Receive Multiple Treatments	Restorative surgery after an accident/injury or treatment for a condition that would prevent patient from working more than three consecutive days if not treated
<input type="checkbox"/> Permanent or Long Term Incapacity	Extended inability to work due to a condition for which treatment may not be effective and patient is under your continuing supervision
<input type="checkbox"/> Chronic Condition  <b>NOTE:</b> See requirements to the right →	Condition requires periodic visits (at least twice per year) for treatment and continues over an extended period of time, and may cause episodic periods of inability to work rather than a continuing period of incapacity. <input type="checkbox"/> Patient will be seen at least twice per year for their Serious Health Condition. Must list approximate dates in Section 5 on page two.
<input type="checkbox"/> Absence Plus Continuing Treatment Consecutive Dates of Inability to Work Start Date _____ End Date _____	Inability to work for more than three consecutive days, treatment on two or more occasions, or treatment on one occasion that results in a regimen of continuing treatment
<input type="checkbox"/> None of the above definitions apply to this patient.	

**Sections 3 through 7 MUST be completed by the Health Care Provider if this application is to be considered complete.**

**SECTION 3B – EMPLOYEE SERIOUS HEALTH CONDITION DETAILS (EMPLOYEE ONLY)  
SEE SECTION 4 FOR CAREGIVER**

**NOTE: A SEPARATE FORM MUST BE USED FOR EACH SERIOUS HEALTH CONDITION.**

Describe the relevant medical facts that support the Serious Health Condition Type selected in Section 3A that are related to the condition for which the employee seeks leave (such medical facts may include symptoms and diagnosis).

**NOTE:** This section is optional for California employees. Do not disclose the underlying diagnosis on this form without the consent of the patient.

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Most Recent Date you treated the Patient for this Specific Condition	Probable Duration of the Serious Health Condition
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Probable Duration of Patient's Present Inability to Work

List Restrictions and Work Functions the employee is unable to perform when incapacitated. (A description of the essential job functions for the employee is available.)

How Does the Serious Health Condition Prevent the Patient from Working?

**SECTION 4 – NON-EMPLOYEE SERIOUS HEALTH CONDITION DETAILS (NON-EMPLOYEE ONLY)**

**NOTE: A SEPARATE FORM MUST BE USED FOR EACH SERIOUS HEALTH CONDITION.**

Describe the relevant medical facts that support the Serious Health Condition Type selected in Section 3A that are related to the condition for which the employee seeks leave (such medical facts may include symptoms and diagnosis).

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Most Recent Date you treated the Patient for this Specific Condition	Probable Duration of the Serious Health Condition
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Describe the care the employee needs to provide for your patient's basic medical needs and why it is medically necessary.

For care of a dependent child 18 or older with physical/mental impairment that substantially limits one or more major life activities, please list the activities of daily living the child is unable to perform.

Can the employee provide this care outside of their work hours?  Yes  No If No, please explain.  
Details

Next Appointment Date

**Sections 3 through 7 MUST be completed by the Health Care Provider if this application is to be considered complete.**

**SECTION 5 – LEAVE DETAILS**

Several questions in Section 4 seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be specific. Terms such as “lifetime” “unknown” or “indeterminate” may be insufficient.

Block FML	Intermittent FML	Reduced-Schedule FML
Block leave: Patient is incapacitated and requires a consecutive block of time away from work due to their serious health condition for three (3) days or more.	Intermittent FML: Episodic flare-ups of the serious health condition of the patient periodically prevents employee from working either as caregiver or for their own serious health condition.	Reduced-Schedule FML: Indicated when the employee requires a reduced number of hours/ days of daily work due to the serious health condition.
<p>Dates of incapacity are:</p> <p>Start Date _____</p> <p>End Date _____</p> <p>Re-evaluation Date _____</p> <p>Employee Return to Work Date _____</p>	<p>Is it medically necessary for the employee to be absent from work during the flare-ups?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If yes, explain in detail:</b> _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Start Date for this Leave _____</p> <p>End Date for this Leave _____</p> <p>Next Appointment Date _____</p> <p>Based upon the patient's medical history and your knowledge of the medical condition, please estimate the frequency of flare-ups (e.g., Per Month 1):</p> <p><b>Maximum Frequency of Episodes:</b></p> <p>_____ Episodes PER _____ Week _____ Month _____ Year (Circle 1)</p> <p>Based upon the patient's medical history and your knowledge of the medical condition, please estimate the duration of each flare-up (e.g., Days 1-2):</p> <p><b>Maximum Duration of each Episode:</b></p> <p>_____ (Circle 1) _____ Hours _____ Days</p>	<p>Start Date for this Leave _____</p> <p>End Date for this Leave _____</p> <p>Approximately how many Hours per day/Days per week should the employee work?</p> <p>_____ HOURS PER DAY</p> <p>_____ DAYS PER WEEK</p> <p>Re-evaluation Date _____</p> <p><b>NOTE:</b> This leave option does not apply to Flight Crew Members.</p>

**SECTION 6 – TREATMENTS/OFFICE VISITS**

Will the patient need to have treatment visits at least twice per year due to the condition?  Yes  No

Was medication, other than over-the-counter medication, prescribed?  Yes  No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  Yes  No

If so, state the nature of such treatments and expected duration of treatment: \_\_\_\_\_

Will the patient need to attend follow-up treatment appointments?  Yes  No

If so, are the treatments medically necessary?  Yes  No

Can the employee schedule required therapy, office visits, treatments, procedures, etc., for themselves or a family member outside of the work schedule?  
 Yes  No If No, what are the reasons?  
 \_\_\_\_\_

\_\_\_\_\_

Estimate treatment schedule, if any, including the dates of any scheduled appointments, and the time required for each appointment, including any recovery period:  
 \_\_\_\_\_  
 \_\_\_\_\_  
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**SECTION 7 – TREATING HEALTH CARE PROVIDER DETAILS**

Health Care Provider's Name (PRINT) \_\_\_\_\_

Today's Date	Type of Practice	State (location) of Practice
Office Phone #	Office Fax	
Treating Health Care Provider's Signature		