



## PHYSICIAN'S CERTIFICATE FOR PAID FAMILY LEAVE

**IMPORTANT:** IN ORDER FOR US TO REVIEW THE CLAIMANT'S REQUEST FOR PAID FAMILY LEAVE, PLEASE COMPLETE THIS FORM WITH THE INFORMATION REGARDING THE CARE RECIPIENT (YOUR PATIENT). UNLESS EACH QUESTION IS ANSWERED, WE CANNOT PROCESS PAYMENTS AND THE CLAIMANT MAY NOT RECEIVE BENEFITS. PLEASE COMPLETE THE FOLLOWING STATEMENT AND **FAX THE FORM TO 818-591-7664**. IF YOU WOULD PREFER TO PHONE IN THE INFORMATION OR HAVE ANY QUESTIONS REGARDING THIS FORM, PLEASE **CALL (818) 591-2772** TO SPEAK TO A SEDGWICK CMS CUSTOMER SERVICE REPRESENTATIVE.

Claimant's Name:	Phone:	Claim Nbr (Mandatory):
Employer Name:		
Care Recipient's (Patient's) Name:	Care Recipient's Date of Birth:	Medical Records Nbr:

**DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT?**     YES (COMPLETE SECTION A)  
 NO (GO TO SECTION B)

**SECTION A**    PLEASE ANSWER ALL QUESTIONS (if applicable) STARTING WITH THE CPT/ICD9 CODE

TYPE	CPT/ICD9 (MANDATORY)	PROCEDURE OR DIAGNOSIS DESCRIPTION (MANDATORY)
PRIMARY		
SECONDARY		

	MM	DD	YY
1. Date medical condition or needed treatment commenced:			
2. First date care is needed:			

3. Approximately how many total hours per day will this patient require care by a care provider?	<b>Nbr of Hrs:</b>
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	MM	DD	YY
4. If the patient will need care only intermittently or on a part time basis, please indicate the probable duration of this need:	<b>Begin Date:</b>		
	<b>End Date:</b>		

4.(a) Please indicate the possible frequency:     Daily     Weekly     Bi-Weekly  
Please Specify Days:     S     M     T     W     TH     F     S

5. What is the expected recovery date?	MM	DD	YY	5.(a) Please mark the appropriate box: (if applicable)
				<input type="checkbox"/> Terminal <input type="checkbox"/> Permanent <input type="checkbox"/> Chronic

6. Date you estimate the patient will no longer require care by the claimant:	MM	DD	YY	<input type="checkbox"/> Unknown
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7. Would disclosure of this certificate to your patient be medically or psychologically detrimental?     YES     NO

**SECTION B** (Physician's Information)

I hereby certify the above statement in my opinion truly describes the patient's serious health condition (if any) and the estimated duration thereof, and that I am:

Physician's Name:	Physician's Specialty:	Lic. Nbr:	State
Address:		City:	St:    Zip:
Telephone Nbr:	Extension:	Fax Nbr:	
SIGNATURE OF ATTENDING PHYSICIAN:			DATE OF SIGNING THIS FORM:

FAX COMPLETED FORM TO **818-591-7664** OR MAIL TO SEDGWICK CMS / PO BOX 9830 CALABASAS, CA 91372-0830  
For questions, call **818-591-2772** between the hours of 6:00 a.m. to 4:45 p.m., Pacific Time.