

First name	Middle initial	Last name	Claim number
------------	----------------	-----------	--------------

Date admitted (mm/dd/yyyy)	Date discharged (mm/dd/yyyy)
----------------------------	------------------------------

Dates you treated the patient for this condition:

First visit (mm/dd/yyyy)	Last visit (mm/dd/yyyy)	Next visit (mm/dd/yyyy)
--------------------------	-------------------------	-------------------------

Are there any other treating physicians or consultants involved in your patient's care? Yes No

In the space provided below, please describe relevant medical facts, if any, related to the condition for which the employee seeks leave from work (*i.e., pregnancy complications, or any regimen of continuing treatment such as the use of specialized equipment*).

Note to California physicians: You may not disclose your patient's diagnosis without your patient's consent.

Job restriction details:

Were you provided with a job description for your patient, or did you discuss the essential functions of their job? Yes No

Is the employee unable to perform any of his/her job functions due to the condition? Yes No

If so, identify the job functions the employee is unable to perform:

SECTION 3: Amount of Leave Needed

Continuous absence details: Will your patient need to be absent from work for a single continuous period of time due to their own serious health condition? If so, please select the checkbox below and provide accurate or estimated dates for this period of absence.

Single continuous absence period	Start date (mm/dd/yyyy)	End date (mm/dd/yyyy)
----------------------------------	-------------------------	-----------------------

Intermittent absence details: Will your patient need an intermittent absence and/or reduced work schedule due to their own serious health condition? If so, please check the box below and provide approximately how long your patient will need the intermittent absence outlined below.

Intermittent absence/Reduced work schedule	Start date (mm/dd/yyyy)	End date (mm/dd/yyyy)
--	-------------------------	-----------------------

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have.

Example: FREQUENCY of episode 02 times per: week, or month, or year
LENGTH of episode: minute(s) 01 hour(s) full day(s)

FREQUENCY of episode times per: week, or month, or year

LENGTH of episode: minute(s) hour(s) full day(s)

First name	Middle initial	Last name	Claim number
------------	----------------	-----------	--------------

SECTION 4: Health Care Provider Information

Physician - First name	Middle name	Last name
------------------------	-------------	-----------

Physician area of specialty (i.e., General Practitioner, Oncologist, Obstetrician)

Office phone number	Office fax number
---------------------	-------------------

Office address	Suite
----------------	-------

City	State	ZIP code
------	-------	----------

Please Read:

GINA Disclaimer: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. *Genetic Information* as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Fraud Notice: Any person who knowingly and with intent to injure, defraud, or deceive any person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information is/may be guilty of a crime and may be prosecuted and punished. Penalties may include fines, civil damages and criminal penalties, including confinement in prison.

By signing below, I attest that I am the treating health care provider to the listed patient. The clinical information I am providing is in regards to the dates of absences listed above. I certify that my patient must be absent from work or have a modified work schedule due to this condition.

Sign Here	Signature of health care provider	Date (mm/dd/yyyy)
	_____	_____

SECTION 5: How to Submit this Form

Mail:	Fax:
MetLife Disability	1-800-230-9531
PO Box 14590	
Lexington KY 40512-4590	