CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS—FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's name Dudley Doo Right

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) ✓ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____ None of the above ____

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above. Knee Replacement Surgery

Date condition commenced: 6/1/07
Probable duration of condition: 4/10/08
Probable duration of the present incapacity (if different): 1-10-08 to 4/10/08

Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of this condition and /or treatments? Yes **Note the probable time and duration.** 3/1/08 to 4/10/08 out patient physical therapy 3 x week: 1 hr each session.

If the condition is chronic (#4) or pregnancy (#3), note if the employee is presently incapacitated and the likely duration and frequency of episodes of incapacity.

N/A

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known.

Physical Therapy 3 x week, 1 hr. each unt.l 4-10-08

Is the employee able to perform the functions of employee's position? NO **If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.**

Unable to work from 1/10/08 unt.l 2/10/08. Upon return No prolonged standing to exceed 2 hrs unt.l 4/10/08

Health Care Provider's Signature [signature] **Date** 1/4/08

Address Full Address of Treating Physicians

6/26/95 APWU FORM 2

CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS—FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's name Dudley Doolright

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) ____ (2) ✓ (3) ____ (4) ____ (5) ____ (6) ____ None of the above ____

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above. Muscle Spasms; Sciatic pain
Unable to stand/walk w/o severe pain

Date condition commenced: 1/8/08
Probable duration of condition: Unknown; Re-evaluation upon completion
Probable duration of the present incapacity (if different): of testing. 1-8-08 to 1/15/08

Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of this condition and /or treatments? Yes **Note the probable time and duration.** 3-5 days per episode; Flare-ups can occur 1-2 times per month. Re-evaluate 03/08

If the condition is chronic (#4) or pregnancy (#3), note if the employee is presently incapacitated and the likely duration and frequency of episodes of incapacity.
N/A

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known.
X-Ray; pain meds; + continued treatment as required

Is the employee able to perform the functions of employee's position? NO **If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.**
No lifting over 10 lbs. Sedentary work; no stooping no bending until re-eval on 3/08

Health Care Provider's Signature _____ **Date** 1/8/08

Address Full address of Physician

6/26/95 APWU FORM 2

CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS—FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's name Dudley DooRight

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) ____ (2) ____ (3) ____ (4) ✓ (5) ____ (6) ____ None of the above ____

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above. Herniated L5/S1

Date condition commenced: 10-26-05

Probable duration of condition: 1 YR.

Probable duration of the present incapacity (if different): 1-8-08 to 2-4-08

Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of this condition and /or treatments? Yes **Note the probable time and duration.** 3-5 days per episode; 4-6 episodes per year.

If the condition is chronic (#4) or pregnancy (#3), note if the employee is presently incapacitated and the likely duration and frequency of episodes of incapacity.

Presently incapacitated unt. 1 2-4-08; see above

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known.

Physical Therapy 3X per week, home therapy, Pain Meds; re-eval 2-14-08.

Is the employee able to perform the functions of employee's position? NO **If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.**

No lifting over 10 lbs; No prolonged standing to exceed 2 hours unt. 1 6-4-08.

Health Care Provider's Signature _____ **Date** 1/8/08

Address Full Address of Treating Physician

APWU FORM 2

6/26/95

CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS—FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's name Dudley Doorright

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ✓ None of the above ____

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above.
Small Cell Malignant Lung Tumor

Date condition commenced: 11/7/07
Probable duration of condition: 1/8/09
Probable duration of the present incapacity (if different): 1-5-08 to 1-10-08

Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of this condition and /or treatments? Yes. **Note the probable time and duration.** 3-5 days per month; chemotherapy treatments once per month unt. 1 6/08

If the condition is chronic (#4) or pregnancy (#3), note if the employee is presently incapacitated and the likely duration and frequency of episodes of incapacity.
N/A

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known.
Chemotherapy once a month unt. 1 6/08. Radiation schedule unknown at this time. Patient will be unable to work 3-5 days per treatment.

Is the employee able to perform the functions of employee's position? NO **If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.**
Patient will experience severe episodes of weakness + will require sedentary work unt. 1 6/08

Health Care Provider's Signature _____ **Date** 1/8/08

Address Full Address of Treating Physician

6/26/95 APWU FORM 2

CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS—FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's name Dudley DooRight

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) ____ (2) ____ (3) ____ (4) ✓ (5) ____ (6) ____ None of the above ____

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above. DIABETES

Date condition commenced: 6/19/1987

Probable duration of condition: 1 yr.

Probable duration of the present incapacity (if different): 1-8-08 to 1-10-08

Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of this condition and /or treatments? yes **Note the probable time and duration.** 1-3 days per episode or flare-up; 2-5 times per year.

If the condition is chronic (#4) or pregnancy (#3), note if the employee is presently incapacitated and the likely duration and frequency of episodes of incapacity.

Unable to work from 1-8-08 to 1-10-08; Return 1-11-08

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known.

Daily insulin / blood glucose monitoring + follow-up office visits every 4-6 months as needed.

Is the employee able to perform the functions of employee's position? yes. **If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.**

Health Care Provider's Signature [signature] **Date** 1/9/08

Address Full address of treating Physician

6/26/95 APWU FORM 2

HEALTH CARE PROVIDER CERTIFICATION OF EMPLOYEE'S FAMILY MEMBER ILLNESS—FMLA

Employee's name Dudley Dooright

Patient's name DONALD DOORIGHT

Relationship to employee ___ Spouse ✓ (Parent) ___ Child *(under age 18 or older and incapable of self care due to a mental or physical disability)*

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) ___ (2) ___ (3) ___ (4) ___ (5) ✓ (6) ___ None of the above ___

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above. Loss of cognitive function
Diminished capacity for self-care

Date condition commenced: 12/06
Probable duration of condition: 1 YR.
Probable duration of the present incapacity (if different): See above

Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of the patient's condition and /or treatments? Yes **Note the probable time and duration.** 3-5 days per month until re-evaluation on or about 12/08

If the condition is chronic (#4) or pregnancy (#3), note if the patient is presently incapacitated (inability to perform regular daily activities) and the likely duration and frequency of episodes of incapacity. N/A

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known. DAILY CUSTODIAL CARE + ASSISTANCE; PSYCHOLOGICAL & EMOTIONAL SUPPORT; TRANSPORTATION FOR ALL PHYSICIAN APPTS &/OR TESTING; 1-3 times per month.

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? Yes **If no, would the employee's presence to provide psychological comfort be beneficial to the patient's recovery?** _____ **Note the probable duration of the need.**

Health Care Provider's Signature [signature] **Date** 1/4/08

Address Full address of treating physician

6/26/95 APWU FORM 3

EMPLOYEE CERTIFICATION OF OWN SERIOUS ILLNESS—FMLA

This form is to be used by employee when requesting FMLA and ***medical documentation is not required pursuant*** *to Sections 513.36 and 515.5 of the ELM.*

Employee's name Dudley Doowright

Description of serious health condition *(On the back of this form is a description of what is meant by a "serious health condition" under FMLA. Does your condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____ None of the above ✓

Date condition commenced 1/8/08

Probable duration of condition 1-8-08 to 1-11-08

The employee must provide a completed Form PS 3971 for each pay period, noting type of leave requested.

Employee's Signature Dudley Doowright **Date** 1/8/08

6/26/95 APWU FORM 1

Submit Medical Documentation
w/ description of serious health condition
w/ diagnosis - prognosis