HEALTH CARE PROVIDER CERTIFICATION FOR EMPLOYEE'S OWN CONDITION

Return to JPMorgan Chase Leave of Absence Service Center
Email: LeaveDoc@Sedgwick.com Fax: (855) 800-5116 | PO Box 14648 Lexington, KY 40512
Phone: (888) 931-3100

Employee Name: Matthew Bobus
Claim Number: 4A2209Q5MLX0001GI
Due Date: 10/16/2022

INSTRUCTIONS to the EMPLOYEE:
Give this form to your healthcare provider. The Family and Medical Leave Act (FMLA) permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

INSTRUCTIONS to the HEALTH CARE PROVIDER:
Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of the condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

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 of the individual, 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.

National Provider Identifier (NPI): 1245287317

Provider's name: Christoff, Eric

Business address: 6500 N. Clark Street Chicago, IL 60626

Type of practice / Medical specialty: Internal Medicine

Telephone: (773) 388 1600 Fax: (773) 564 4156

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PART A: MEDICAL FACTS

1. Approximate date condition commenced: 9/19/2022 but condition has been chronic for years prior

   Provide your **best estimate** of how long the condition lasted or will last: Ongoing

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ~~No~~ ___Yes

   If yes, dates of admission: _____

   Date(s) you treated the patient for condition, including telemedicine visits conducted by video conference:
   9/13/2022 6/21/2022 2/21/2022 11/15/2021

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ✓ Yes

   Was medication, other than over-the-counter medication, prescribed? ___No ✓ Yes

   Was the patient referred to any other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

   ✓ No ___Yes

   If yes, state the nature of such treatments and expected duration of treatment:
   Vyvanse 50mg once daily Adderall 20 Mg twice daily

2. Is the medical condition pregnancy? N/A ___No ___Yes If so, expected delivery date: _____

3. For the following question, use the job information provided by the employer. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ✓ No ___ Yes
   If yes, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   NOTE: In California and Connecticut, do not disclose the underlying diagnosis unless you have received consent from the patient.

Pt is requesting accomodation to work 8 less hours per week all on one work day. This is in order to improve the amount of time he has to exercise weekly and to get adequate sleep to ensure current dosages of ADD medications continue to work without developing tolerance which could cause a need to increase dosage levels.

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PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ✓ No ___ Yes

   If yes, estimate the beginning and ending dates for the period of incapacity: _____ through _____

6. Will the employee need to work part-time or on a reduced schedule because of the employee's medical condition? ___ No ✓ Yes

   If yes, are a reduced number of hours of work medically necessary? ___ No ✓ Yes

   Estimate the part-time or reduced work schedule the employee needs, if any: 8 hour(s) per day; 1 days per week

   Estimate the beginning and end date of the part-time or reduced work schedule: 9/19/2022 through 12/31/2022

7. Will the employee need to attend follow-up treatment appointments because of the employee's medical condition?

   ___ No ✓ Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period (e.g. 1 appointment every 3 months, and requires 1 day of recovery per appointment):

   Frequency: _____ appointment(s) every _____ week(s) ***or*** 3 month(s)

   Duration: 4 hours ***or*** ___ day(s) per appointment

   Estimate the beginning and end date of the follow-up treatment appointments: On going through _____

8. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ✓ No ___ Yes

   Is it medically necessary for the employee to be absent from work during the flare-ups? ___ No ___ Yes
   If yes, explain:

   _____

   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 over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) ***or*** _____ month(s)

   Duration: _____ hours ***or*** ___ day(s) per episode

   Estimate the beginning and end date of the episodic flare-ups: _____ through _____

What are the disabling side effects the employee may experience due to the treatment?

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____ 10/2/2022

Signature of Health Care Provider Date