Attending Physician's Statement **To be completed by the Treating Physician of the Care Recipient (Incomplete forms will be returned)**	**Paid Family Leave**	**Email or Fax to: TRISTAR** Tel: 844/702-2352 Fax: 562/495-6687 Email: ICSFax@tristargroup.net

DO NOT COMPLETE THIS FORM IF REASON FOR PFL LEAVE IS BONDING WITH A CHILD

PFL Claimant's (Care Provider's) Name (First, Middle, Last):

Patient's (person requiring the care) Name (First, Middle, Last):

Patient's Date of Birth:	Does your patient require care by the Care Provider? ☐ No ☐ Yes	First date care is needed:	Date you estimate patient will no longer require care by the Care Provider:

ICD-10 or DSM code:	Secondary ICD-10 or DSM code:	Date patient's condition commenced:	Date you expect recovery:

If Diagnosis not yet determined, provide a detailed statement of symptoms:

Approximately how many total hours per day will patient require care by the care provider?

Hours: _____ Comments: ____

OR Will the patient require intermittent care? ☐ Yes ☐ No

Start Date: ______________ End Date: ______________

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) _____ month(s)

Duration: _____ hours or ____ day(s) per episode

Would disclosure of this Certificate to your patient be medically detrimental? ☐ Yes ☐ No

I hereby certify that the above statements truly describe the patient's disability (if any) and the estimated duration thereof. If I am a Nurse Practitioner I certify that I performed a physical examination of the above patient and that I collaborated with a physician prior to certifying the period of disability stated above.

Type of Physician/Practitioner:	Specialty:
Print or Type Physician's/Nurse Practitioner's Name as shown on License:	State License #:
Address:	City, State, Zip:
Telephone:	Fax:
Signature (NO STAMP):	Date Signed: (MM/DD/YYYY)