WORK CONNECTIONS
UNIVERSITY OF MICHIGAN
Illness and Injury Assistance

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Medical Leave Form (To be completed by a treating licensed health care provider)

A. PATIENT INFORMATION

Please print or type in black ink

1. Name of patient		Date of birth	Date health condition commenced?
2. Date of initial appointment	Date of next appointment	Has or will the patient need at least two appointments for treatment per year due for this condition? Y☐ N☐	

B. MEDICAL INFORMATION

3. Primary diagnosis	ICD 10	GAF
4. Secondary diagnosis	ICD 10	GAF

5. Subjective symptoms	Able to perform activities of daily living Y☐ N☐ Self care Y☐ N☐ Able to drive Y☐ N☐
6. Objective findings (diagnostic tests, laboratory or clinical findings)	
7. Treatment plan (medications, procedures, therapy, referrals)	

C. HOSPITALIZATIONS and SURGICAL PROCEDURES (if applicable)

8. Name of hospital	Date of admission	Date of discharge
9. Surgical procedure	Date performed/scheduled	CPT procedure code

D. MEDICAL LEAVE and RETURN TO WORK INFORMATION

10. Will the patient require a continuous medical leave of absence from work for this condition? Y☐ N☐ If yes:
Duration of leave needed: _____ days☐ weeks☐ months☐ First date unable to work: _____ Estimated return to work date: _____
Will this health condition require treatment and absence from work for more than 12 continuous months? Y☐ N☐

11. Will this health condition result in episodic flares and intermittent leave from work? Y☐ N☐ If yes: _____
Episodes per month: _____ Days per episode: _____ Duration of time intermittent leave will be needed:_____ weeks☐ months☐

12. Will the patient need to attend future appointments for treatment? Y☐ N☐ If yes: Number of appointments _____ per week☐ per month☐
Duration of appointments: _____ hours☐ minutes☐ Estimated date treatment will be completed: _____

13. Will the patient need a reduced work schedule? Y☐ N☐ If yes: _____
Hours per day able to work: _____ Number of days able to work per week: _____ Date able to return to a full schedule: _____

14. Are work restrictions needed? Y☐ N☐ If yes, check those that apply: Grasp☐ Reach☐ Lift☐ Kneel☐ Squat☐ Walk☐ Bend☐ Twist☐ Other☐
Please specify below any restrictions checked (e.g., No lift over 10 pounds, No reach above shoulder with right arm, Other restrictions)

_____

Estimated date restrictions will end: _____ Will restrictions last more than 6 months? Y☐ N☐

15. Are there cognitive impairments? Y☐ N☐ If yes, check those that apply: Memory☐ Concentration☐ Comprehension☐ Other☐ _____
Are these impairments severe enough that work restrictions or accommodations will be needed? Y☐ N☐ If yes, please clarify below:

E. LICENSED HEALTH CARE PROVIDER INFORMATION

Health care provider's name (please print):	Signature:	Date: Email:
Degree/specialty/credentials:	Address:	Phone: Fax: