Attending Physician's Statement To be completed by the Treating Physician of the Care Recipient (Incomplete forms will be returned)	**Paid Family Leave** ________________________ Employer Name	**Mail or Fax to:** **TRISTAR Benefit Administrators** PO Box 32363, Long Beach, CA 90832 Tele: 877/874-3518 Fax: 562/495-6687

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 Social Security Number:

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:

The Genetic Information Non-Discrimination 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's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

ICD9 Code:	Secondary ICD9 Codes:	Date patient's condition commenced:	Date you expect recovery:

The patient needs assistance with the following activities of daily living (check all those that apply):

☐ Bathing or showering ☐ Dressing ☐ Eating ☐ Getting in or out of bed or chairs
☐ Walking ☐ Using the toilet
Comments:

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

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 doctor:	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