

<b>Attending Physician's Statement</b>  <b>To be completed by the Treating Physician of the Care Recipient</b>  <b>(Incomplete forms will be returned)</b>	<p align="center"><b>Paid Family Leave</b></p> <hr/> <p align="center">Employer Name</p>	<b>Mail or Fax to:</b> <b>Innovative Care Systems, Inc.</b> Integrated Disability Claims Dept. PO Box 11433 , Torrance, CA 90510 Phone: 800/965-1444 Fax: 310/943-0348
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**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:
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Patient's Date of Birth:	Does your patient require care by the care provider? <input type="checkbox"/> No <input type="checkbox"/> Yes	First date care is needed:	Date you estimate patient will no longer require care by the care provider:
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Diagnosis or, if not yet determined, a detailed statement of symptoms:

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

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

I certify under penalty of perjury that, based on my examination, this Physician's Certificate truly describes the patient's condition and need for care and the estimated duration thereof.

Type of doctor:	Specialty:
Print or Type Physician's Name as shown on License	State License #
Address	City, State, Zip
Telephone	Fax
Signature: (NO STAMP)	Date