



## FAMILY AND MEDICAL LEAVE ACT (FMLA) PACKET

### This packet contains:

- Instructions to Complete the FMLA Packet
- FMLA Notice of Rights and Responsibilities
- Request for Leave of Absence Form
- Health Care Provider Certification Form
- Authorization Form for the Disclosure of Health Information
- Short Term Disability Claim Form
- Return to Work Certification

### **Special Notice:**

You must notify the Company at least **15 calendar days** prior to any proposed period of leave is to begin of the intention to take a planned or foreseeable leave.

In the event of an unplanned or unforeseeable leave, notice of the need for leave must be provided to the Company as soon as the leave arises, however no later than **2 business days** after the commencement of the leave.

THE FAILURE OF AN EMPLOYEE TO TIMELY NOTIFY THE COMPANY OF THE NEED FOR LEAVE MAY RESULT IN THE DELAY OR DENIAL OF THE LEAVE REQUEST. FAILURE TO PROVIDE THOROUGH AND COMPLETE ANSWERS TO THE QUESTIONS FOUND IN THIS PACKET MAY DELAY THE APPROVAL PROCESS.

If You Have Questions Regarding an Upcoming Leave of Absence  
Call the Benefits/Disability Department 1-866-233-7511

**STEP 1:** Review the **FMLA Policy Notice of Rights and Responsibilities**

**STEP 2:** Employee completes **Request for Leave of Absence Form**

- To provide appropriate notice of leave of absence, you are required to complete Sections 1 through 3 of the Request for Leave of Absence Form.
- Failure to provide thorough and complete answers on the request form may delay the leave approval process.
- You must attach a current work schedule if the leave is to be taken intermittently, or if it will be necessary for you to work less than your regular schedule.
- Send the completed form to the attention of: Disability/Benefit Specialist at fax number: 920-749-4230 or 1-866-585-2620, IAD employees must use fax number 703-572-5058.

**STEP 3:** Employee's Treating Health Care Provider completes the **Health Care Provider Certification Form**

- The Health Care Provider Certification Form needs to be completed by the health care provider who is treating the employee or family member as applicable.
- The treating physician is requested to provide as much information as possible when completing the certification form. Omitted or incomplete information may delay the process of determining an employee's eligibility for leave.
- The certification must be provided to the Company within 15 calendar days of notice to you of the need to provide such information. Send the completed form to the attention of: Disability/Benefit Specialist at fax number: 920-749-4230 or 1-866-585-2620, IAD employees must use fax number 703-572-5058.
- If the need for a leave is due to a serious health condition **of the employee**, complete Step 4 as outlined below.

Upon receipt of the Request for Leave and the Health Care Provider Certification forms, the Benefit/Disability Department will determine the adequacy of the information supplied and will notify the employee if the leave request will be approved, denied or if additional information is required.

**Note:** The Company may require the employee to periodically submit additional Health Care Provider Certification forms during the approved leave as necessary.

**STEP 4:** Employee completes the **Authorization Form for the Disclosure of Health Information**

- If the need for leave is **due to an employee's serious health condition**, the employee must complete this form in its entirety and submit to the attention of:
  - a) Disability/Benefit Specialist at fax number: 920-749-4230 or 1-866-585-2620  
IAD employees use fax number 703-572-5058 and
  - b) your treating physician.

**STEP 5:** Employee and Treating Physician completes the **Short Term Disability Claim Form**.

When an employee's sick leave allowance (and vacation allowance for pilots) has been exhausted because of a non-work related serious health condition, and **the employee** is still disabled and unable to return to work, per Company policy, an employee may be eligible for Short Term

Disability (STD) benefits.

- Employee completes Section 1 of the Short Term Disability Claim Form. The form should then be sent to your treating physician.
- The treating physician completes Section 2 (and Section 3 for pilots) and submits the completed form to the attention of: Disability/Benefit Specialist at fax number: 920.749.4230 or 1-866-585-2620, IAD employees must use fax number 703-572-5058.

If approved, short term disability will be paid in accordance with Company policy or the appropriate collective bargaining agreement.

**STEP 6: Treating Physician completes Return to Work Form**

- Prior to returning to work, an employee will be required to have their treating physician complete the Return to Work form and submit it to the attention of: Disability/Benefit Specialist at fax number: 920.749.4230 or 1-866-585-2620, IAD employees must use fax number 703-572-5058.

## FMLA POLICY - NOTICE OF RIGHTS & RESPONSIBILITIES

The following information concerns your rights and obligations under the family and medical leave law and explains the consequences of your failure to meet these obligations. Please read the information carefully, and if you have questions, please contact the Benefits/Disability Department at 1-866-233-7511.

- Leave Entitlement.** Under federal law, employees are generally entitled to 12 work weeks of unpaid leave during a calendar year. Certain state laws differ (refer to the state supplements in the FMLA policy). To be eligible for leave, you must have been employed by Air Wisconsin for 12 months and have worked required hours for leave eligibility must request leave not fewer than 15 calendar days before your leave is to begin, unless, due to the circumstances, a shorter notice is necessary. However, notice must in all cases be given not later than three workdays after leave begins. Leave may be taken on an intermittent or reduced leave schedule basis for a serious health condition, only after attempting to coordinate the period of absence with the Company. In the event of a birth, adoption or foster care placement, intermittent leave will be permitted as required under state law.
- Medical Certification.** If your leave request is based on your own serious health condition or the serious health condition of your child, spouse or parent, you must provide the Company with a Health Care Provider Certification prepared by your treating health care provider. The certification must be provided to the Company within 15 calendar days of notice to you of the need to provide such information, unless the Company agrees to an extension of time. If the certification is incomplete or insufficient, the Company may request a clarification from your health care provider. Written clarification must be completed and returned to the Company within 7 calendar days unless the Company agrees to extend the response time. In the event questions continue to exist, your health care provider may be contacted for clarification of the request. If you or your health care provider fails to provide a timely certification, your leave request, or your continuation of leave, may be denied. If your leave request is denied, your absences will be classified under the Company's attendance policy.
- Additional Certifications.** If the Company has any doubts regarding the accuracy of the Health Care Provider Certification, you must submit to another examination, at the Company's expense, by a health care provider selected by the Company. If the second health care provider opinion differs from the initial health care provider, a third opinion, from a mutually agreed upon health care provider, may be required. The third opinion is final and binding.
- Recertification.** You must provide the Company, to the extent required by law; with recertifications on a periodic basis that your serious health condition prevents you from performing your job functions or that you are needed to care for a family member with a serious health condition.
- Return to Work.** If you are on FMLA leave due to your own serious health condition, you will be required to provide the Company with a return to work certificate, signed by your health care provider, which addresses your ability to perform the essential duties of your job, before you can return to work. If you fail to provide the Company with a return to work certificate, your reinstatement may be denied until the required certification is provided.
- Substitution.** You may have the option of using certain types of paid leave, i.e., short-term disability or vacation, for unpaid family and/or medical leave pursuant to the Company's FMLA Policy. The Company may require you to use your accrued paid leave for any unpaid leave period. When paid leave is used for your unpaid leave, the paid leave will not be available to you later. These leaves will run concurrently, provided you meet any applicable requirements of the leave policy, which are outlined in the summary previously provided to you. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave. Leave required for a work related injury will run concurrently with your point of coverage under worker's compensation benefits.
- Maintenance of Health Insurance Coverage.** Your health insurance coverage and other Company provided benefits will continue in full effect during your leave provided the required premium contribution is paid. If you elect to use paid leave, or if the Company requires the use of paid leave, your share of premiums will be paid through the Company's normal payroll deduction method. Otherwise, you must pay the required contribution on a monthly basis during the period of unpaid leave, as requested by the Company.

8. **Employment Protection**. Upon returning to work from family or medical leave, you will be reinstated to the position you held prior to leave or, if your position is no longer available, to an equivalent position with equivalent pay, benefits, and other terms and conditions of employment, unless your employment would otherwise have ceased. You will have no greater right to employment at the end of your leave than you would have had with the Company if you had not taken leave. If your leave extends beyond your 12 week FMLA entitlement, the Company may fill your position.
9. **Recovery of Premiums**. If you fail to return to work after your family or medical leave, for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or 2) other circumstances beyond your control, you may be liable to the Company for any health coverage premiums paid during your leave.
10. **Designation of Leave**. When the Company receives any requested information, we will inform you whether your leave will be designated as FMLA leave. If you do not provide the Company with the required information within the time specified, your absence may be classified as other than family and/or medical leave.

**If your absence qualifies as FMLA, you have the following responsibilities while on FMLA**

You must contact the Benefits/Disability Department to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave if applicable. You have a 30 day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 calendar days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

If the leave is for your serious health condition, you will be required to present a fitness-for-duty certification to be restored to employment, unless you are directed in writing by the Company not to provide such information. If such certification is not timely received, your return to work may be delayed until a certification is provided. A list of the essential functions of your position is attached to your Health Care Provider Certification.

# Request for FMLA Leave Form

Employee Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Employee #: \_\_\_\_\_  
 Full-Time  Part-Time  
 Date Leave Requested to Begin: \_\_\_\_\_ Position: \_\_\_\_\_ Location: \_\_\_\_\_

## SECTION I – TYPE OF LEAVE

**I request the following type of leave of absence:**

- |  |  |
|--|--|
| <input type="checkbox"/> Medical Leave for my own serious health condition                 | <input type="checkbox"/> Uniformed Service Leave (Please attach orders)                      |
| <input type="checkbox"/> Medical Leave for an immediate family member (1)                  | <input type="checkbox"/> "Qualified Exigency" relating to active duty (Please attach orders) |
| <input type="checkbox"/> Parental Leave for birth or placement for adoption or foster care |  |
| <input type="checkbox"/> Service member Leave  |  |

(1) Spouse, child or parent

Reason for Requesting Leave (please be specific): \_\_\_\_\_  
 \_\_\_\_\_

For leave to care for an **immediate family member** with a serious health condition or an ill and injured servicemember, please indicate the following:

- Full name of person to be cared for  parent,  spouse,  child: \_\_\_\_\_
- If the person is your child, the age of the child: \_\_\_\_\_
- The care to be provided (please be specific): \_\_\_\_\_

For "**Qualified Exigency**" leave, please indicate the situation the employee is needed to address (i.e., arrange for childcare, attend pre-deployment briefings, etc.): \_\_\_\_\_

## SECTION 2 – AMOUNT OF LEAVE TO BE TAKEN

**I request that the leave be granted for the following period of time:**

Requested Start Date of Leave: \_\_\_/\_\_\_/\_\_\_ Requested End Date of Leave: \_\_\_/\_\_\_/\_\_\_

**YOU MUST** Attach a schedule if leave is to be taken intermittently or if it will be necessary to work less than your regular schedule

**I would like to substitute the following paid leave time during my family or medical leave:**

- Vacation Days \_\_\_\_\_ (number of days)  
 Sick Days\* \_\_\_\_\_ (number of days)

**\*Employees reporting to work in WI:** For FMLA, sick days may be used for birth or adoption (up to 6 weeks) or for family members' serious medical conditions (up to 2 weeks).

During unpaid leave, I will chose the following method of payment of medical premiums: \_\_\_\_\_ Payroll deduct upon return  
 \_\_\_\_\_ I will make monthly payments by check to: **Air Wisconsin Airlines Corporation**

## SECTION 3 – EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and disciplinary action up to and including discharge. Travel Privileges: I understand that while on approved Family and Medical Leave, I and my eligible dependents will have online travel privileges for the duration of my leave. If Family and Medical Leave is not granted, travel privileges are suspended for the duration of the leave.

**I acknowledge that I have read and understand the guidelines for Family and Medical Leave.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED IN ITS ENTIRETY BY TREATING PHYSICIAN**  
**Fax Completed Form to: Attention Disability/Benefit Specialist at 1-866-585-2620, IAD employees use 703-572-5058**

**NOTE TO TREATING HEALTH CARE PROVIDER:** Please avoid use of the terms “lifetime,” “unknown,” or “indeterminate,” when responding to questions relating to the frequency or duration of a condition or its treatment. Using such terms may not be sufficient to determine eligibility for FMLA coverage. Please provide as much information as possible when completing this certification. **Omitting information or not providing complete information may cause delay or denial of leave eligibility for your patient.**

A) I, \_\_\_\_\_, confirm that \_\_\_\_\_  
(Name of Health Care Provider or Christian Science Practitioner) (Patient's Name)

**is under my care for an illness or injury, impairment or physical or mental condition involving (check the appropriate box(es):**

- Inpatient care** in a hospital, hospice or residential medical facility
- Any period of absence that renders the person **incapable** of performing work, training, or other regular activities; and involves **continuing treatment or supervision** by a health care provider
- Continuing treatment** by (or under the supervision of) a health care provider for a chronic or long-term health condition that is **incurable or so serious** that it may result in a period of incapacity
- Any period of absence that renders the service person who is a family member unable to perform the duties of his/her rank
- Prenatal care
- None of the above

B) **In addition, my understanding is that the patient is one of the following (check the appropriate box):**

- An employee of Air Wisconsin Airlines Corporation
- The spouse of an employee of Air Wisconsin Airlines Corporation
- The son or daughter of an Air Wisconsin Airlines Corporation employee
- The parent of an Air Wisconsin Airlines Corporation employee
- A service member who has incurred a serious illness or injury in the line of duty and is the son, daughter, spouse or next of kin of the employee of Air Wisconsin Airlines Corporation
- None of the above

C) **Accordingly, I confirm that:**

1. My area of medical practice is: \_\_\_\_\_
2. The health condition commenced on \_\_\_/\_\_\_/\_\_\_ and has a probable duration through \_\_\_/\_\_\_/\_\_\_.
3. The patient was first seen by me relative to, and treated for, this health condition on \_\_\_/\_\_\_/\_\_\_.
4. In addition, I have provided care to the patient on the following date(s) (list all dates of treatment or supervision):

\_\_\_\_\_

\_\_\_\_\_

5. The patient's condition has manifested itself for the dates of absence in question in the following manner (specifically describe including impact on ability to work, attend school or perform activities of daily living):

\_\_\_\_\_

\_\_\_\_\_

6. If the individual is a service member who has incurred a serious illness or injury in the line of duty, please specify how the patient's condition has manifested itself (specifically describe impact on ability to perform the duties of his/her rank):

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Please describe the origin of the service member's illness or injury:

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7. I will be providing care to the patient on the following dates (list all dates of treatment or supervision):

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8. The patient was treated on an  inpatient  outpatient basis (check as applicable).

9. Was medication, other than over-the-counter medication, prescribed?  Yes  No

If Yes, please describe impact on patient:

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10. Describe other relevant medical facts, including symptoms, diagnosis, or any regimen of continuing treatment.

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11. Was the procedure/treatment scheduled in advance or on an emergency basis? If scheduled in advance, please indicate how many days in advance the treatment was scheduled.

Scheduled in advance                       Emergency Basis

Date scheduled: \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments, if any: \_\_\_\_\_

**D) If the patient is an employee:** the health condition must render the employee unable to perform the functions of his or her position which means the employee is unable to work at all or is unable to perform the essential functions of the position.

1. Is the employee able to perform the following employment functions during the period over which the absence from work occurred/is occurring:

**Yes    No**

- Standing for 30 minutes or less
- Standing for more than 30 minutes but less than 2 hours (with or without breaks)
- Standing for more than 2 hours (with or without breaks)
- Sitting for 30 minutes or less
- Sitting (with or without breaks) for more than 30 minutes but less than 2 hours
- Sitting (with or without breaks) of 2 hours or more
- Walking short distances (20 yards)
- Arm movement (if limited please note below)
- Lifting less than 20 pounds
- Lifting 20 or more pounds
- Speaking
- Environmental concerns    If Yes, please comment: \_\_\_\_\_

2. Is the employee limited to **working 40 or less hours per week** (exclusive of breaks and other time off of active work?)

Yes     No    If Yes, please comment: \_\_\_\_\_

3. If the employee requires **intermittent** (leave taken in separate blocks of time) **or reduced leave** (leave that reduces the employee's hours per workweek or workday) which is medically necessary, please describe why the intermittent or reduced leave is medically necessary.

\_\_\_\_\_  
\_\_\_\_\_

Please identify the dates on which treatment/care is to be provided: \_\_\_\_\_

How long will the employee need to be absent for each appointment? \_\_\_\_\_

\_\_\_\_\_

**E) If the patient is the spouse, son, daughter or parent of the employee:** the health condition of such individual must require that the employee is needed to care for such individual. A health condition for such individual must be such that affects an individual's ability to engage in normal daily activities.

1. The employee will be needed to care for the spouse, parent, son or daughter on the following dates: \_\_\_\_\_

\_\_\_\_\_

(Please indicate which portion of such days will be required for care, i.e., hours needed for care, morning/afternoon or evening)

2. If applicable, what is the expected date of birth of the child? \_\_\_\_\_

3. Is the patient incapable of performing certain activities of daily living without assistance from the employee? If so, please indicate which of the following may not be performed by the patient because of the patient's condition (check as appropriate):

- |  |   |
|--|---|
| <input type="checkbox"/> Personal grooming             | <input type="checkbox"/> Personal hygiene   |
| <input type="checkbox"/> Bathing                       | <input type="checkbox"/> Dressing           |
| <input type="checkbox"/> Eating                        | <input type="checkbox"/> Cooking & cleaning |
| <input type="checkbox"/> Shopping                      | <input type="checkbox"/> Using a telephone  |
| <input type="checkbox"/> Other (please specify): _____ |   |

4. Describe care of the son, daughter or parent to be provided by the employee: \_\_\_\_\_

\_\_\_\_\_

5. If the employee requires **intermittent** (leave taken in blocks of time) **or reduced leave** (leave that reduces the employee's hours per workweek or workday) to care for the employee's spouse, parent, son or daughter, please describe why it is medically necessary:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please identify the treatment schedule (dates and times): \_\_\_\_\_

\_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
Signature of Health Care Provider/  
Christian Science Practitioner

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address 1

\_\_\_\_\_  
Address 2

\_\_\_\_\_  
City/State/Zip Code

***Important Note: Certain states have enacted anti-fraud provisions making it a crime to provide false information to obtain for oneself or another employee benefit from an employer. Specifically, Wis. Stat. Section 943.395 prohibits anyone from knowingly providing false or fraudulent information in the presentation of a claim, or any proof in support of such claim to be paid under any contract or certificate of insurance; or prepares, makes or subscribes to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing with knowledge that the same may be represented or used in support of a claim for payment under a policy of insurance; or presents or causes to be presented a false or fraudulent claim or benefit application or any false or fraudulent proof in support of such a claim or benefit application or false or fraudulent information which would affect a future claim or benefit application to be paid under any employee benefit program created by Chapter 40; or makes any misrepresentation in or with reference to any application for membership or documentary or other proof for the purpose of obtaining membership or in or noninsurance from any fraternal subject to Chapter 600-646 from himself, or herself or any other person.***

# Short Term Disability Claim Form

**TO BE COMPLETED BY EMPLOYEE AND TREATING PHYSICIAN AS FOLLOWS:**

Employee must complete **Section I**. Treating Health Care Provider must complete **Section II**.

AME must complete **Section III** (Pilots Only)

**Fax Completed form to: Attention Disability/Benefit Specialist at Fax 1-866-585-2620, IAD employees use 703-572-5058**

**SECTION I – To be Completed by Employee**

NAME OF EMPLOYEE	AWAC EMPLOYEE NUMBER:
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ADDRESS

REASON FOR CLAIM <input type="checkbox"/> ILLNESS <input type="checkbox"/> INJURY	IF INJURY, PROVIDE DATE, PLACE AND HOW IT HAPPENED.
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WAS ILLNESS OR INJURY WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW LONG WERE YOU OR WILL YOU BE PHYSICALLY UNABLE TO WORK? _____ Date First Unable to Work: ___/___/___ Date Returned to Work: ___/___/___
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**AUTHORIZATION TO RELEASE INFORMATION**

I AUTHORIZE my physician, hospital, clinic, or other related medical facility to furnish my employer, Air Wisconsin Airlines Corporation, its acting agents, or other representatives, detailed information regarding treatment, diagnosis, and prognosis while under their care for the dates listed above. I UNDERSTAND information obtained with this authorization will be used to determine eligibility for coverage. I CERTIFY that the information provided above is true and correct to the best of my knowledge. I understand that misrepresentation of these facts may cause a delay or forfeiture of Short Term Disability benefits and may result in disciplinary action up to and including termination.

THIS AUTHORIZATION IS VALID UNTIL \_\_\_\_\_ or for the duration of this claim.

DATE	EMPLOYEE'S SIGNATURE
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**SECTION 2 – Treating Physician Statement**

Nature of illness or injury (include diagnosis code):

Date and Nature of Surgical or Obstetrical Procedure (if any):

Patient has been continuously disabled (unable to work): From: _____ Through: _____	Pregnancy: Please provide approximate date pregnancy commenced and expected delivery date: Date: _____ Due Date: _____
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If still disabled, date patient should be able to return to work: Date: _____	Is patient still under your care for this condition? If no, please explain. <input type="checkbox"/> Yes <input type="checkbox"/> No
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PHYSICIAN'S NAME (PRINT):	PHONE:
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PHYSICIAN'S SIGNATURE/DEGREE:	STREET ADDRESS:
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DATE:	CITY, STATE, ZIP
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**SECTION 3 – Pilot Only (Must be completed by AME before STD benefit can be awarded)**

AME Name (Print):	Date patient first disabled (unable to work):
	Date Patient should be able to return to work:

AME Signature:	Date of FAA Medical Exam:
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# Return to Work Certification Form

Name: \_\_\_\_\_

Return to Work Date: \_\_\_\_\_

To Whom It May Concern:

The individual named above is currently employed as a *Flight Attendant* with Air Wisconsin Airlines Corporation. In the course of their regular duties, the following may be required of this individual on a regular or periodic basis:

## DESCRIPTION OF TASK(S)/CONDITION(S)

- 1. Lifting of items weighing as much as 35 pounds, such as galley equipment and carry-on baggage.
- 2. Duty days ranging from 2 - 14 hours with a minimum rest period of 8 hours between days of work.
- 3. Pressurization several times a day ranging from sea level to approximately 8,000 feet in elevation. In emergency conditions such as a decompression cabin altitude could approach 30,000 feet for a short period of time.
- 4. Frequent bending (20%) to obtain galley supplies.
- 5. Pushing and pulling of galley equipment weighing up to 115 pounds.
- 6. Handling of in-flight emergencies which could necessitate rapid evacuation of the aircraft with an associated jump of between 5 – 6 feet to the ground.
- 7. Opening and closing, pushing and pulling of aircraft doors up to a maximum force of 50 pounds vertical or horizontal.
- 8. Must be able to kneel (5%), squat (10%) with extended reach 10 inches above head (5%) and extended reach 30 inches in front of body (30%).

Is the patient taking any medication that may affect their ability to perform their job duties?

No \_\_\_\_\_ Yes \_\_\_\_\_ if yes, please describe \_\_\_\_\_

**Having read the above duties it is my medical opinion that this individual:**

is **NOT** able to perform all of the duties checked above.

is **ABLE** to perform all of the duties checked above.

This letter will remain in force until additional communication is received stating that the individual is no longer capable of meeting the guidelines set forth above.

\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Physician's Signature

Date