Health Care Provider Certification Form Instruction Sheet

I. **Please review the instruction sheet (pages 1 & 2) and the Team Member Information Sheet (pages 3 & 4).** If you have questions, contact the Absence and Return Center (ARC) at 1-800-447-2000. Detailed information regarding the FMLA policy is on Jetnet.

II. **Log onto Jetnet to ensure the accuracy of your permanent and alternate mailing addresses on file.**

In order to have FMLA Leave approved, as described below, you must be administratively eligible under the FMLA, satisfy timely your notice obligations, and seek leave for a qualifying FMLA within the administrative timelines.

A. **Team Member Administrative Eligibility:** You are administratively eligible for FMLA Leave if:

1. You have at least 12 months of company service as of the actual start date of the FMLA leave and,

2. You have worked at least 1,250 hours during the 12-month period immediately preceding the start of the requested FMLA leave.

   a. Hours worked do not include vacation, paid sick, holidays, injury on duty time, crew layover time, leave time, etc.

   b. Pilots and Flight Attendants must have worked or been paid for not less than 60 percent of the applicable monthly guarantee and worked or been paid for not less than 504 hours excluding sick or medical leave or vacation time during the previous 12-month period.

B. **Team Member Notice Obligations:**

1. If your need for leave is foreseeable, you must notify your supervisor and the ARC at least 30 calendar days in advance of the date on which your FMLA leave will begin. If 30 days' notice is not practicable, such as because of a lack of knowledge of approximately when leave will be required to begin, a change in circumstances, or a medical emergency, notice must be given as soon as practicable (generally within 2 business days of learning of the need for leave).

2. If your need for leave is *unforeseeable*, you must notify your supervisor and the ARC of your need for FMLA leave as soon as practicable and in compliance with your department's usual and customary requirements for calling off of work, absent unusual circumstances.

3. If your need for leave is for your own or a family member's serious health condition, you must provide sufficient medical certification of the need for leave to the Company within 15 calendar days of the date on which such certification is requested by the Company (additional time may be requested in some circumstances).

   a. If the submitted medical documentation requires additional information or clarification, you will be notified and given an opportunity to provide the additional information to the ARC within 15 calendar days of the notification.

   b. Be sure the treating health care provider is aware of the deadlines you have been given.

4. If your need for leave is for reasons other than your own or a family member's serious health condition (e.g., family military leave), you may be asked to provide required supporting documentation (see Jetnet)

C. **Qualifying Reasons for FMLA Leave**– Eligible team members may take FMLA for the following reasons:

1. For the birth of a son or daughter, and to care for the newborn child;
2. For placement with you of a son or daughter for adoption or foster care;
3. To care for your spouse, son, daughter or parent with a serious health condition;
4. Because of your own serious health condition that makes you unable to perform the functions of your job;
5. Because of any qualifying family military exigency; and
6. To care for a covered service member with a serious injury or illness.

III. **Complete the FMLA Certification Form on pages 5 – 7**

A. **Section A** – Items 1 through 5 (page 5) – to be completed by you, the **team member**.

B. **Section B** – Items 7 through 21 (pages 6 & 7) – To be completed only by the health care provider treating the serious health condition for which you are requesting the FMLA Leave. Do not make alterations to the information documented by the treating health care provider. Your health care provider may need a copy of your Essential Job Functions. (Please contact your local supervisor if required).

IV. **Submit the FMLA Certification Form**

A. You must fax, email or mail the completed form to the Absence & Return Center (ARC). **Fax: 1-855-709-4903 or email: ARC.LOA@aa.com or mail: Absence & Return Center, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616**

B. **Your FMLA leave status will be updated on Jetnet within two-three business days from the date it is received.** Please keep a copy of this form for your records.

C. **Note:** It is your responsibility to ensure American Airlines ARC receives the completed FMLA Certification Form.

V. **Verify the status of your FMLA**

A. Check the status of your leave request on Jetnet. Select “Team Member Services”, then select “Leaves and Returns”. Under FMLA, click on “FMLA Status”. The FMLA Status page will show the current and prior FMLA leaves. Click on “View” to see the comments of your current case. If there is not a current case, then the ARC has not created a case for you.

B. If ARC has not created a case for you within 3 business days from the fax date, then ARC did not receive your form. Resend your completed form and ensure you keep your fax confirmation sheet.

VI. **Designated / Not designated FMLA leave -** After your FMLA form is submitted, your leave will either be ‘Designated’ or ‘Not Designated’.

A. **Designated:** Your specified time away from work is designated for FMLA Leave.

B. **Not Designated:** Your specified time away from work is not designated for FMLA Leave.

VII. **Type of FMLA Leave -** FMLA Leave may be taken as a Regular / Block, Intermittent, or Reduced Schedule leave. (Note the difference below)

A. **If you are requesting FMLA Block/Continuous Leave:**

1. **FMLA Block/Continuous Leave** – a one-time continuous leave for a serious health condition. Some collective bargaining agreements (CBAs) provide for a Medical/Sick Leave of Absence if you are in need of a block leave for your own condition and all Sick/Medical eligibility criteria are met. The company will require such leave to run concurrently with FMLA leave.

2. Absences that do not fall between the designated start and end dates of your designated leave may not be coded as FMLA or Sick/Medical leave and may be considered an attendance occurrence under the applicable attendance policy.

3. Returning to work prior to the end date of your designated block leave will end your leave. Medical certification will need to be provided if you are in need of a new block leave after having returned to work from your designated leave.

4. If you need to extend the designated end date of your block/continuous leave, it is your obligation to provide notice to the Company of the requested extension as soon as practicable (typically within 2 business days of learning of the changed circumstances). After receiving notice of a requested leave extension, the Company may require you submit a new medical certification completed by the appropriate health care provider. That certification must be provided to the Company within 15 calendar days of the date on which such certification is requested by the Company, absent extenuating circumstances. Failure to provide timely notice and/or proper certification of any leave extension may result in a delay or denial of your leave coverage.

B. **If you are requesting Intermittent FMLA Leave or a Reduced Leave Schedule:**

1. **Intermittent FMLA Leave** – leave taken in separate blocks of time for a single qualifying reason.

2. **Reduced Leave Schedule** - a leave schedule that reduces the usual number of working hours per workweek, or hours per workday *(Example: your health care provider indicates that you should only work 4 hours per day for 6 weeks due to your health condition.)*

3. When using Intermittent FMLA leave or a Reduced Leave Schedule, you must advise your supervisor of the need for leave as soon as practicable under the circumstances. Please be advised that you must comply with your department’s usual and customary requirements for calling off of work, absent unusual circumstances.

4. Team members needing foreseeable intermittent FMLA Leave or a Reduced Leave Schedule for planned medical treatment must attempt to schedule their leave so as to not disrupt the operation. This includes, but is not limited to, scheduling appointments with the health care provider, therapy sessions, medical procedures, etc., at times when you are not scheduled to be at work. You may be reassigned to an alternative position with equivalent pay and benefits that better accommodates your foreseeable intermittent or reduced leave schedule.

Team Member Information

The following information is provided to help inform you of your FMLA rights and obligations in a simple manner. All terms and definitions will always be interpreted consistent with the FMLA law and/or regulations.

Annual Amount of FMLA Leave
In most cases, if you are not a flight crew member, eligible team members may take a maximum of 12 workweeks of FMLA Leave per rolling calendar year. Eligible flight crew team members are entitled to take a maximum of 72 days of FMLA leave during the 12 month period. If your request has been designated as FMLA Leave, this leave will count against your annual FMLA Leave allotment. If you have FMLA Leave designated for a family member who was a service member injured/ill in the line of duty, your FMLA allotment (excluding flight crew) cannot exceed a maximum of 26 weeks in a single 12-month period, measured forward from the date of your first FMLA leave to care for the covered service member. Flight crew may take a maximum of 156 days within a single 12-month period to care for a covered service member. When using military caregiver leave, there is a combined cap of 26 weeks for any FMLA leave during a single 12-month period for non-flight crew, and a combined cap of 156 days for any FMLA leave taken by flight crew members during a single 12-month period. All designated FMLA Leave usage, for all conditions, will count against your annual FMLA Leave allotment.

Attendance Policy
Unless determined to be eligible for protection through the FMLA recertification process or under other laws, policies or a collective bargaining agreement, absences that do not fall between the designated start and end dates, or absences for other reasons will not be coded as FMLA Leave and may be considered an attendance occurrence under the applicable attendance policy.

Benefit Coverage
While you are on FMLA Leave, you are still responsible for any team member premiums for any team member benefits at the same rate you paid while actively working. If your FMLA Leave is paid, these contributions will continue to be deducted from your paycheck. If your FMLA Leave is unpaid and you have been removed from payroll, subsequent payments need to be made by the due date indicated on your monthly payment notice sent by Aon Hewitt. You will receive detailed benefit information in the mail which will explain how to make payments during your unpaid FMLA Leave. If you do not receive benefit information within 10 days of starting your unpaid FMLA Leave, please call the **Benefits Center at: 1-888-860-6178**. It is your responsibility to ensure that benefit premiums are being paid while you are on leave. If you fail to pay for optional coverage(s) such as life insurance and disability, your coverage may lapse.

Birth/Adoption/Foster Placement
You are required to provide certification of birth, adoption or foster care placement by submitting Section A and one of the 3 following items: 1) estimated due date, 2) date of birth, or 3) documentation of the adoption or foster care placement of the child.

Job Restoration
With limited exceptions, you are entitled to your same or an equivalent job in your current location at the end of your FMLA Leave. Your rate of pay will be determined by company policies in effect at the time of your return.

Life Event
An FMLA unpaid leave of absence is considered a Life Event that allows you to make changes to your benefit plan in accordance with the plan provisions.

Misrepresentation/Misuse
Misrepresentation of any kind in your application for and/or misuse of FMLA Leave is a direct violation of company policy, and you may be subject to corrective action, up to and including termination.

Outside Employment While on FMLA Leave
Outside employment while on a leave of absence must be approved by your Leader and the People Department. Failure to get approval may result in discipline up to and including termination

Paid Holidays
Absences during a holiday on which you were originally scheduled to work do not generally qualify for holiday pay. Please refer to your Collective Bargaining Agreement and/or any applicable policies to determine if you will be eligible for holiday pay during a FMLA-related absence.

Paid Leave Substitution
Unless otherwise stipulated by an applicable collective bargaining agreement, American Airlines requires the use of certain paid leave concurrently with your FMLA Leave. Team members are advised to check their workgroup specific policies and/or Collective Bargaining Agreement.
* *Certain state laws may allow you to use a portion of your available paid sick time when providing care to an eligible family member.*

Reduction in Force
FMLA Leave does not protect you from layoff. A team member who would be laid off while active can still be laid off while on FMLA Leave.

Return to Work Certification Requirements
If you take FMLA leave for your own serious health condition, then prior to returning to work you will be required to provide the Company with a written certification from your treating healthcare provider stating that you can perform the essential functions of the job. If you need to provide a return to work certification, you will receive notice from the Company and will be provided with the return to work certification form that must be completed by your health care provider. Should you fail to provide the required return to work certification prior to your scheduled return to work, then your return to work may be delayed or denied.

State and Municipality Laws
Certain states or municipalities may have their own laws regarding similar types of family care or medical leave. To the extent consistent with applicable law, any overlapping FMLA designated absences will team member run concurrently with applicable state or local laws.

Spouse
The FMLA defines a “spouse” as a husband or wife, including same-sex or common law marriage, as defined or recognized under state law for purposes of marriage in the state where the marriage was entered into, or, if the marriage is valid in the place where entered into and could have been entered into in at least one state.

Domestic Partner (DP)
The federal FMLA does not include Domestic Partner (DP) as an eligible family member. However, the Company will provide leave similar to FMLA to a DP, if the team member has complied with the requirements of the Company’s Domestic Partner Program.

Travel Privileges
Travel privileges for domestic team members while on an approved leave of absence are determined by the type of leave. Please refer to the travel sections on Jetnet for additional details.

Frequently Asked Questions and Answers

Q1. How soon should I notify the Company that I need to take FMLA Leave?
A1. If your need for leave is foreseeable based on an expected birth, placement for adoption or foster care, planned medical treatment for a serious health condition of the team member or of a family member, or the planned medical treatment for a serious injury or illness of a covered service member, you must notify your supervisor at least 30 calendar days in advance when you plan to use any type of FMLA Leave of the date on which your FMLA leave will begin. If 30 days' notice is not practicable, such as because of a lack of knowledge of approximately when leave will be required to begin, a change in circumstances, or a medical emergency, notice must be given as soon as practicable (generally within 2 business days of learning of the need for leave).

If your need for leave is unforeseeable, you must notify your supervisor as soon as practicable and in compliance with your department's usual and customary requirements for calling off of work, absent unusual circumstances. Team members must provide sufficient medical certification of the need for leave to the Company within 15 calendar days of the date that such certification is requested by the Company, absent extenuating circumstances.

Q2. Can I verify that the Absence and Return Center (ARC) received my application for FMLA Leave?
A2. You can check the status of your FMLA request on Jetnet.

Q3. My doctor's office says they faxed my application, but the Absence and Return Center didn't receive it. What should I do?
A3. Call the health care provider's office and find out who handles the administrative tasks such as faxing medical documents. Ask this person to send the information again either via fax or U.S. Mail. If the form is sent via fax, ask them to keep a copy of the confirmation page. If they send it via U.S. Mail, ask them to maintain a copy of the application in your medical record. Be sure your health care provider's office understands the timelines by which your application must be received. Timeline extensions will not be granted, unless it is not practicable under the circumstances, despite your diligent, good faith efforts.

Q4. Should I keep a copy of my FMLA application after the health care provider completes his/her portion?
A4. Absolutely! You can check the status of your FMLA request on Jetnet.

Q5. My doctor's office charges me a fee to complete the paperwork and fax it to the Absence and Return Center. Who should I send the bill to?
A5. AA is not responsible for this cost. If your health care provider charges a fee for completing or faxing the FMLA application, it is your responsibility to pay for the services. To minimize your costs, be sure the form is completed fully the first time. You should discuss your needs with the health care provider prior to having the FMLA forms completed.

Q6. My doctor did not answer one of the questions on the FMLA Certification Form. Can I answer it myself?
A6. No. Do not answer any of the questions on Section B or Section C of the FMLA Certification Form. This is considered misrepresentation and may result in corrective action, up to and including termination.

Q7. The Absence and Return Center has indicated that my doctor did not answer questions 19a and 19b on the request for intermittent FMLA Leave. I contacted my doctor and asked him to provide the information, but he said, "I can't answer that because I can't predict when you are going to be too sick to go to work." What should I do?
A7. Questions 19a and 19b ask the health care provider to provide an estimate of the frequency and duration under which you may need to take intermittent FMLA Leave. This is not a "prediction" of when you will be ill. However, the health care provider should consider the prior medical history of this health condition and estimate how often it typically causes you to become incapacitated and how long each episode typically lasts. For example, in the past, you may have become physically incapacitated once every two months, and each episode may have lasted anywhere from 1 day to 3 days. In addition, based on your history, you routinely follow-up with your health care provider for this condition about once every 3 months. These are the kinds of facts that should be provided, and they should be based only on your current medical need for leave.

Q8. The Absence and Return Center (ARC) has asked the health care provider to submit additional medical facts to support the medical necessity of the intermittent FMLA Leave. What does this mean?
A8. This means that your health care provider should document the medical facts to support your request for FMLA Leave. For example, your physician has documented that you need to take off twice a month, 2 to 3 days each time for the next six months for "leg pain". Additional medical facts to support your need for leave may include items such as symptoms, hospitalization, doctor visits, whether medication has been prescribed, any referrals for evaluation or treatment (physical therapy, for example), or any other regimen of continuing treatment.

Q9. I have a lot of questions about FMLA Leave. Where should I go for answers?
A9. If you have questions regarding the FMLA leave request process or need information regarding the company FMLA policy, log onto Jetnet. If you have questions that are not answered by the FMLA policy, contact your supervisor or FMLA coordinator. You may also contact the Absence & Return Center at 1-800-447-2000.

Health Care Provider Certification Form - Section A – Completed by the Team member

1. _____ _____ _____ _____
First Name Last Name AA Employee# Base

_____ _____
Email Address Phone Number

Your Job:

O Admirals Club	O Cargo	O Flight Attendant	O Planner
O Agent	O Credit Union	O Fueler	O Reservations
O Aircraft Mechanic	O Facilities Maintenance	O Management	O Support Staff
O Auto Mechanic	O Fleet Service - Ramp	O Pilot	O Other: _____

In the past seven years have you:

O Yes O No Been on military leave?

O Yes O No Worked as a contractor or temporary team member for American Airlines?

2. **Are you requesting this leave of absence for your own serious health condition?**

O Yes O No If No, this leave is to provide care for my: (does not apply to MLOA)

O Baby Bonding*	O Son	O Father	O Spouse	O Adoption / Foster Placement*
O Birth*	O Daughter	O Mother	O Domestic Partner	O Other: _____

* You are required to provide certification of birth, adoption or placement by submitting Section A and one of the following: 1) Estimated due date, 2) date of birth or 3) documentation of the adoption or foster care placement of the child.

_____ _____ _____ _____
Family Member's First Name Family Member's Last Name Date of Birth Age

3. **For baby bonding**- please provide the start and end dates for the bonding period (must take place within 12 months following the birth, (does not apply to MLOA)):

Start Date: _____ End Date: _____

4. **Notification** - Please print your supervisor's first and last name below:

_____ _____
Supervisor's First Name Supervisor's Last Name

5. **Acknowledgement -** By signing this document I acknowledge that:
- I have received, read and understand all pages of this document.
- I have access to the Company's FMLA policy.
- I can check the status of my FMLA leave on Jetnet.
- I have not made or will not make any alterations to the information documented by the treating healthcare provider.
- I have not completed any of the questions of Section B, which is to be completed only by the treating health care provider.
- An ARC representative may need to contact my treating health care provider to clarify or authenticate this form and has permission to do so.
- I affirm that both my permanent and alternate mailing addresses on the file with the company are accurate.
- It is my responsibility to ensure this completed form and any additional information requested at a later date is submitted to and received by the ARC via fax or U.S. mail within the administrative timelines listed on page 1.
- Misrepresentation of any kind in my application for and/or use of FMLA are subject to corrective action, up to and including termination.

_____ _____
Signature Date

6. **Submitting the completed form** – You must fax, email or mail the completed form to the Absence & Return Center (ARC). By fax, send the completed form to the ARC and retain your fax transmittal sheets or mail to the Absence and Return Center's address below. **Your FMLA leave status will be updated on Jetnet within two-three business days from the date it is received.** Please keep a copy of this form for your records.

Fax completed form to 1-855-709-4903 or email to: ARC.LOA@aa.com or mail to:
Absence & Return Center, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616

Health Care Provider Certification Form - Section B – Completed by the Patient's Health Care Provider

First Name	Last Name	AA Employee #	Base
_____	_____	_____	_____

Items 7-21 MUST be completed by the treating health care provider to provide American Airlines with a confidential certification of your patient's health conditions. This certification is needed so we can determine if we can designate the requested leave as FMLA. Please answer all applicable parts of this certification fully and completely. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can. Terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Please limit your responses to the condition for which the patient is seeking leave. Please complete all that apply for condition that you are treating the patient for.

7. Approximate date condition commenced: _____ / _____ / _____

8. Probable duration of condition: _____

9. Was patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?

   ___ No ___ Yes If so, dates of admission: _____ / _____ / _____ through _____ / _____ / _____

10. Date(s) you treated the patient for condition in the last year: _____

11. Will the patient need to have treatment visits at least twice per year due to the condition?

    ___ No ___ Yes If so, provide the dates of the last two office visits and the date(s) of next visit: _____

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

13. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

    ___ No ___ Yes If so, state the nature of such treatments and expected duration of treatment_____

    _____

14. Is the medical condition pregnancy?

    ___ No ___ Yes If so, expected delivery date: _____ /_____ /_____

15. If you are not provided a list of the patient's essential functions or a job description, answer this question based upon the patient's own description of his/her job functions. Is the patient unable to perform any of his/her job functions due to the condition?

    ___ No ___ Yes If so, identify the job functions the team member is unable to perform: _____

    _____

    _____

16. Describe other relevant medical facts, if any, related to the condition for which the team member seeks leave (may include any regimen of continuing treatment such as the use of specialized equipment): *Note to California Healthcare Providers: Do not answer this question without written consent from the patient.*

    _____

    _____

    _____

17. For chiropractic use only

    ___ No ___ Yes Has Subluxation of the spine has been demonstrated to exist by x-ray imaging? Date of x-ray_____

    ___ No ___ Yes Is the patient being treated by manual manipulation of the spine for subluxation of the spine.

Fax completed form to 1-855-709-4903 or email to: ARC.LOA@aa.com or mail to:
Absence & Return Center, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616

Health Care Provider Certification Form - Section B – Completed by the Patient's Health Care Provider

First Name	Last Name	AA Employee #	Base
_____	_____	_____	_____

Questions 18-20, enter the start and end dates of the appropriate type(s) of leave in the columns below that apply for your patient's condition. The medical facts (question 16) on this form must substantiate the type(s) and length of leave requested.

18. **Regular/Block/Continuous –** is indicated when the employee or family member is incapacitated and requires a single block of time away from work due to the serious health condition. **Dates of incapacity are:** Start Date: _____ / _____ / _____ End Date: _____ / _____ / _____ Please note, the dates of incapacity are not necessarily the dates of absence from work (e.g. trip sequence or scheduled work days).	19. **Intermittent –** is indicated when the employee requires leave in intermittent periods of time away from work due to the employee or family member's serious health condition or for treatment. (does not apply to MLOA) Start Date: _____ / _____ / _____ End Date: _____ / _____ / _____ ***Complete A and/or B as they pertain to the patient's condition.*** *If absences due to treatment are not applicable please enter N/A in B.* **A. Frequency of leave for episodes of incapacity:** _____# times/episodes per:*(select only one)* ○ year, ○ month, or ○ week **For a duration of:** *(select only one)* _____# hours, or _____# day(s) per episode **B. Frequency of leave for treatment:** _____# times/episodes per:*(select only one)* ○ year, ○ month, or ○ week **For a duration of:** *(select only one)* _____# hours, or _____# day(s) per episode ***Example:*** *4 times/episodes per year lasting 1-2 days each time* ***A. Frequency of Leave:*** *__4__ # times/episodes per:* ● *year* ○ *month* ○ *week* ***For a duration of:*** *(select only one)* *_____# hours, or* *__1-2__# day(s) per episode*	20. **Reduced-schedule** – is indicated when the employee requires a reduced number of hours of daily work due to the employee or family member's serious health condition. Start Date: _____ / _____ / _____ End Date: _____ / _____ / _____ Estimate the part-time or reduced work schedule the team member needs, if any? ____# hours per day; ___# days per week

21. **Treating Health Care Provider Information**

Name (Please print)	License #
Type of practice	State (location) of practice
Office phone #	Office fax #

By signing this form, you are certifying that you are the treating health care provider for this condition.

Treating Health Care Provider's Signature	_____ / _____ / _____ Today's Date

Fax completed form to 1-855-709-4903 or email to: ARC.LOA@aa.com or mail to:
Absence & Return Center, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616

Please note: *The Genetic Information Nondiscrimination 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 ask 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 or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Health Care Provider Certification Form - Section C – Completed by the Patient's Health Care Provider
Only Complete for the Care of an Adult Child

First Name	Last Name	AA Employee #	Base
_____	_____	_____	_____

FMLA Leave may be taken to provide care for a son or daughter age 18 or older if that child is incapable of self-care because of a mental or physical disability.

Definitions

- Son or Daughter – a biological, adopted, foster, step-child, a legal ward, or a child of a person standing in loco parentis, who is either under age 18, or age 18 and older and incapable of self-care because of a mental or physical disability.
- Incapable of self-care – the individual requires active assistance or supervision to provide daily self-care in three or more of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs). ADLs include adaptive activities such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating. IADLs include cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, using a post office, etc.
- Physical or Mental Disability – a physical or mental impairment that substantially limits one or more of the major life activities of an individual.

To be completed by the Adult Child's Treating Health Care Provider for this Condition

Patient's First Name	Patient's Last Name
_____	_____

Please **check all** of the boxes next to the ADLs and/or the IADLs which require the employee to assist his/her adult child:

☐ Bathing	☐ Hygiene	☐ Other: (Please List)
☐ Cleaning	☐ Medical Care	_____
☐ Cooking	☐ Paying Bills	_____
☐ Dressing	☐ Shopping	_____
☐ Eating	☐ Taking Public Transportation	_____
☐ Grooming	☐ Using Telephones and Directories	_____

22. **Treating Health Care Provider Information**

Name (Please print)	License #
_____	_____
Type of practice	State (location) of practice
_____	_____

Office phone #	Office fax #	Best day/time to contact
_____	_____	_____

By signing this form, you are certifying that you are the treating health care provider for this condition.

Treating Health Care Provider's Signature	Today's Date
_____	_____ / _____ / _____

Fax completed form to 1-855-709-4903 or email to: ARC.LOA@aa.com or mail to:
Absence & Return Center, MD 5132, P.O. Box 619616, DFW Airport, TX 75261-9616