



**To Use Connecticut Paid Family And Medical Leave To:
Care for a family member with a serious health condition**

Complete Form CT PFML -1

- Complete CT PFML-1, Part A
- Provide CT PFML-1 to employer
- Employer completes CT PFML-1, Part B and returns to you within 3 days

Complete Form CT PFML -3

- Care recipient completes CT PFML-3 and provides to health care provider
- Care recipient's health care provider keeps CT PFML-3

Complete Form CT PFML -4

- Complete "Employee" information at the top of CT PFML-4
- Provide CT PFML-4 to care recipient's health care provider
- Care recipient's health care provider completes CT PFML-4 and returns to you

Send forms and documents

- Send completed forms and supporting documentation to The Standard
- The Standard accepts or denies claim within 5 days once a complete claim is received.

Please keep a copy of all pages for your records.

- To request Connecticut Paid Family And Medical Leave (CT PFML), the employee requesting CT PFML must complete Part A of the *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1) with the required additional form to The Standard. The employee should retain a copy of each submitted form for their records.

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting CT PFML must complete all required information.

Connecticut Paid Family And Medical Leave (CT PFML) Request (to be completed by the employee)

Question 10: Family member means an employee's spouse, sibling, son or daughter, grandparent, grandchild, parent (includes parent-in-law), or an individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of those family relationship.

Child means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands in *loco parentis*.

Grandchild means a child of the employee's child.

Grandparent means a parent of the employee's parent.

Parent means the biological, parent-in-law, adoptive, step-brother or step-sister of the employee.

Spouse means a husband or wife or domestic partner of an employee.

Family Member Equivalent: an individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of those family relationship.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested CT PFML. These dates should be the actual dates that the CT PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates CT PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If dates are estimated, The Standard may require you to submit a request for payment after the CT PFML day is taken. Payment for approved claims will be due 15 calendar days from the date of the claim decision.

Question 12: Date employer was notified. If the employee is submitting the CT PFML request to their employer with less than 30 days' advance notice from the start date of the CT PFML, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 14: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 19: List all other income you will be receiving while on CT PFML. Include the type/name of income and how much. Example PTO from employer for \$500.00 a week.

If you are pre-submitting form: Indicate if the employee is pre-submitting their CT PFML request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by The Standard, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The Standard will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Payment for approved claims will be due 15 calendar days from the date of the claim decision.**

If The Standard does not permit pre-submitting, The Standard must return the Request for Connecticut Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting CT PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

“Wage” or “wages”: For the purpose of payment of benefits, means a Covered Employee’s remuneration from the Employer for employment and dismissal payments.

Weekly Wages: means an amount equal to one twenty sixth, rounded to the next lower dollar, of a Covered Employee’s Total Wages, as defined in subsection (b) of Section 31-222 of the general statutes, or self-employment income, as defined in 26 USC 1402(b), as amended from time to time, earned during the two quarters of the Covered Employee’s base period in which such earnings were highest.

Employer signs and dates, and then returns to the employee requesting CT PFML within three business days.

Be sure to complete the appropriate additional CT PFML form(s) based on the type of CT PFML leave being requested.

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)		2. Other last names, if any, under which employee has worked				
3. Employee's mailing address Street		City		State	Zip Code	Country (if not USA)
4. Employee's Social Security Number or TIN		5. Employee's date of birth (MM/DD/YYYY)		6. Employee's primary telephone number ()		
7. Employee's preferred email address while on CT PFML (if available)				8. Employee's gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other		
9. Reason for CT PFML request: <input type="checkbox"/> Bond with child <input type="checkbox"/> Adoption/Foster child <input type="checkbox"/> Care for family member <input type="checkbox"/> Employee Impacted by Family Violence <input type="checkbox"/> Military qualifying event <input type="checkbox"/> Military Caregiver: Care of a family member injured in the line of duty <input type="checkbox"/> Own serious health condition due to Covered Employee serving as a Bone Marrow Donor <input type="checkbox"/> Own serious health condition due to Covered Employee serving as an Organ Donor <input type="checkbox"/> Own serious health condition due to pregnancy <input type="checkbox"/> Own serious health condition (other)						
10. The family member is employee's: <input type="checkbox"/> Child <input type="checkbox"/> Spouse or registered domestic partner <input type="checkbox"/> Family Member Equivalent <input type="checkbox"/> Sibling <input type="checkbox"/> Parents and legal guardians (or spouse's parent) <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild						
11. Will CT PFML be for a continuous period of time and/or periodic? <input type="checkbox"/> Continuous ____ / ____ / ____ CT PFML start date (MM/DD/YYYY) ____ / ____ / ____ CT PFML end date (MM/DD/YYYY) <input type="checkbox"/> Dates are estimated Identify dates periodic CT PFML will be taken: <input type="checkbox"/> Periodic _____ <input type="checkbox"/> Dates are estimated						
12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:						

Employment Information (to be completed by the employee)

13. Business name		14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)	
15. Has your employment ended? If so, what was your termination date?				
16. Employee's work location Street address				
City		State	Zip code	Country (if not U.S.A.)
17. Employer's telephone number for contact regarding this request. ()		18. Is employee currently receiving Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. List income you will be receiving while on CT PFML, source of pay and amount.				
20. Have you taken any leave in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. If yes list dates and type of leave.		

Disclosure statement: Information regarding CT PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Employee's signature	Date signed (MM/DD/YYYY)
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I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address			
Mailing address			
City	State	Zip code	Country (if not U.S.A.)
2. Employer's FEIN			
3. Employer's EIN		4. Employer's contact name for questions related to CT PFML	
5. Employer's contact telephone number ()	6. Employer's contact email address		
7. Employee's date of hire (MM/DD/YYYY)	7a. Employee's last day of work (MM/DD/YYYY)		
8. Employee's Weekly Wages			
9. Employee's Typical Work Week Hours			
10a. Check Days Normally Worked <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday			
10b. Is employee hourly or salaried? <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried			
11. List the last date the employee will receive pay, for example the last date through which sick leave benefits, if any, will be paid.			
12. Will any full days of accrued paid time* be used in place of PFML benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please provide dates where full days of accrued paid time is being used. _____ <i>*Accrued paid time could be sick leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off. Use of full days of accrued paid time, in place of PFML benefits, will not decrement the employee's PFML bank.</i>			
13a. What type of paid benefits will the employee receive while on CT PFML? Include the last date through which any compensation will be paid.			
13b. Is the leave request a result of employee's injury on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has the employee applied for Worker's Compensation payments/benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has the employee received Worker's Compensation payments/benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount of Weekly Payment/Benefit: \$ _____ Effective date of benefits: _____			
14. CT PFML policy number			
CT PFML insurance carrier's name and mailing address Standard Insurance Company PO Box 3877 Portland, OR 97208 866-751-5174 Fax			
Declaration and signature <input type="checkbox"/> I affirm the employee meets the eligibility for Connecticut Paid Family And Medical Leave. Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.			
Employer's authorized signature		Date signed (MM/DD/YYYY)	
Title			

**Connecticut Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form CT PFML-3)**

Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

- If an employee is requesting Connecticut Paid Family And Medical Leave (CT PFML) to care for a family member with a serious health condition, the family member or an authorized representative must complete a *Release Of Personal Health Information For Family Member* (Form CT PFML-3) and submit it to their health care provider, along with a copy of the *Certification For Care Of Family Member* (Form CT PFML-4).
- The *Release Of Personal Health Information For Family Member* (Form CT PFML-3) enables the health care provider to complete *Certification For Care Of Family Member* (Form CT PFML-4) and release it to the employee seeking CT PFML benefits.
- Before completing and signing, the family member must read the *Release Of Personal Health Information For Family Member* (Form CT PFML-3) in its entirety.
- The employee requesting CT PFML submits both the *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1) and the *Certification For Care Of Family Member* (Form CT PFML-4) to their employer's CT PFML insurance carrier, for CT PFML benefit determination.

NOTE: This form will be retained by the health care provider. The employee should make a copy for their records before giving it to the health care provider.

Family member or authorized representative signs and dates.

This form is given to the family member's health care provider along with the *Certification For Care Of Family Member* (Form CT PFML-4).

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's health care provider with Form CT PFML-4)

Employee enters their name, and family member's name and date of birth at the top of each page.

The CT PFML insurance carrier name requested at the top of the form is the same as the CT PFML insurance carrier identified in *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1) Part B line 13.

Family member or authorized representative must complete all applicable requested information.

If a family member is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the family member. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

**Connecticut Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form CT PFML-3)**

Standard Insurance Company

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PO Box 3877 Portland OR 97208

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Family member's legal name	Family member's date of birth (MM/DD/YYYY)
Relationship of family member to employee	If family member is employee's son or daughter, date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's health care provider with Form CT PFML-4)

<p>I, _____, authorize my health care provider listed on this form to <div style="text-align: center; margin-left: 100px;">Family member's legal name</div> release my personal health information to _____ and Standard Insurance Company. <div style="text-align: center; margin-left: 100px;">Employee's legal name</div></p> <p>Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Connecticut Paid Family And Medical Leave benefits.</p> <p>Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.</p> <p>This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:</p> <p><input type="checkbox"/> HIV/AIDS related information <input type="checkbox"/> Mental health information <input type="checkbox"/> Alcohol/drug treatment <input type="checkbox"/> Psychotherapy notes</p>			
Health Care Provider Information (to be completed by the family member or authorized representative)			
Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for CT PFML benefits.			
1. Health care provider's name			
2. Health care provider's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
3. Health care provider's telephone number (provide area or country code) ()			

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For Family Member
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Standard Insurance Company

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PO Box 3877 Portland OR 97208

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first legal name, middle initial, last name)	
Family member's legal name (first name, middle initial, last name)	Family member's date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's health care provider with Form CT PFML-4)

Family member Information (to be completed by the family member or authorized representative)			
4. Family member's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
5. Family member's Social Security Number		6. Family member's telephone number (provide area or country code) ()	

READ AND SIGN BELOW

I have a serious health condition and thereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition* (Form CT PFML-4) to the employee identified on Form CT PFML-4, I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting CT PFML benefits as a result of my current condition.

Family member's signature	Date signed (MM/DD/YYYY)
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Authorized representative

I, _____, represent the family member in this matter as authorized by:

Print legal name

Parental right Power of attorney (attach copy) Court order (attach copy) Health care proxy (attach copy)

Authorized representative's signature	Date signed (MM/DD/YYYY)
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The employee should retain a copy for their own records.

To Be Completed by Employee

INSTRUCTION to the EMPLOYEE: The employee requesting Connecticut Paid Family And Medical Leave (CT PFML) to care for family member with a serious health condition must submit the *Certification For Care Of Family Member (Form CT PFML-4)* with *Request For Paid Family and Medical Leave (Form CT PFML-1)*. Fill out the employee information of this form and give to the health care provider along with *Release Of Personal Health Information For Family Member (Form CT PFML-3)*. When you receive the completed *Certification For Care Of Family Member (Form CT PFML-4)* from the healthcare provider, send the completed forms and supporting documentation to The Standard.

Employee's Name				
Employee's Address	City	State	ZIP	Phone No.
Family member's Name	Relationship of family member to employee	Family member date of birth		
Family member's Address	City	State	ZIP	Phone No.

To Be Completed By Health Care Provider**INSTRUCTIONS for HEALTH CARE PROVIDERS**

This form is used to certify a serious health condition in order to qualify for CT PFML. Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the family member.

SERIOUS HEALTH CONDITION

A “**serious health condition**” is defined as a condition that involves inpatient care or continuing treatment by a health care provider.

- “**Treatment**” includes examinations to determine if a serious health condition exists and evaluations of the condition.
- A “**regime of continuing treatment**” includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition.
- It does not include taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.
- A person has a “serious health condition” if he/she has one or more of the following conditions summarized below:

Inpatient Care:

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

(Note: If surgery is elective, and an overnight stay in the hospital is required, leave is covered.)

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity and Treatment: A period of incapacity of more than three consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity, unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider.

Examples: the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy.

Chronic Conditions Requiring Treatments: Any period of incapacity due to or treatment for a chronic serious health condition which:

- Requires periodic visits for treatment by a health care provider at least twice a year; and
- Recurs over an extended period of time; and
- May cause episodic rather than a continuing period of incapacity.

Examples: asthma, migraine headaches, diabetes, epilepsy

Permanent/Long-Term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider.

“**Serious health condition resulting in incapacitation that occurs during a pregnancy**” means:

- Prenatal medical appointments
- Pregnancy-related complications
- Recovery from pregnancies that do not end in a live birth
- Childbirth and delivery, and
- The period of time after the delivery during which the biological mother is certified by her doctor to be unable to perform the requirements for her job.

HEALTHCARE PROVIDERS

“Health Care Provider” means:

- A doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices,
- A podiatrist, dentist, clinical psychologist, or optometrist authorized to practice in the state and performing within the scope of his or her practice;
- A chiropractor authorized to practice in the state and performing within the scope of his or her practice;
- A nurse practitioner, nurse-midwife, clinical social worker, or physician assistant authorized to practice in the state and performing within the scope of his or her practice;
- A Christian Science practitioner listed with the First Church of Christ, Scientist, in Boston, Massachusetts; or
- Any health care provider from whom the employer or the employer’s group health plan’s benefits manager will accept a medical certification to substantiate a claim for benefits.

PART A: MEDICAL FACTS

1. Diagnosis _____ Primary ICD Code (optional) _____

Approximate date condition commenced: _____ Probable duration of condition: _____

Was the family member admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes No

If so, dates of admission: _____

Date(s) you treated the family member for condition: _____

Will the family member need to have treatment visits at least twice per year due to the condition? Yes No

Was the family member referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes No

If so, state the nature of such treatments and expected duration of treatment: _____

2. Is the medical condition pregnancy? Yes No If so, expected/actual delivery date: _____

3. Complications with the pregnancy or delivery? Yes No Please explain: _____

4. Describe other relevant medical facts, if any, related to the condition for which the family member needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

5. Is the family member an active service member? Yes No

If yes, is the condition a result of military service? Yes No

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your family member's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

6. Will the family member be incapacitated for a single continuous period of time, including any time for treatment and recovery? Yes No

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the family member need care? Yes No

Explain the care needed by the family member and why such care is medically necessary: _____

7. Will the family member require follow-up treatments, including any time for recovery? Yes No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

Explain the care needed by the family member, and why such care is medically necessary: _____

8. Will the family member require care on an intermittent or reduced schedule basis, including any time for recovery? Yes No

Estimate the hours the family member needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the family member, and why such care is medically necessary: _____

9. Will the condition cause episodic flare-ups periodically preventing the family member from participating in normal daily activities?

Yes No

Based upon the family member's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the family member 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

Does the family member need care during these flare-ups? Yes No

Explain the care needed by the family member, and why such care is medically necessary _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name		Date	
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice		License No.	

Declaration and signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Signature of Health Care Provider	Date
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