SYRACUSE ORTHOPEDIC SPECIALISTS

PAID FAMILY LEAVE ACKNOWLEDGEMENT

Patient Name:_____ **DOB:**_____

Family Member requesting leave:_____

SOS Provider the patient is seeing:_____

You are submitting a New York State Paid Family Leave form for completion and submission by SOS so that your request will be accepted.

Please note that before we can complete this form, we need you to be certain to discuss the following items with the patient's provider at the visit today.

Length of time that you will be needed to take care of your family member:

- ☐ 1 week
- ☐ Other length of time:_____
- ☐ Greater than 1 week, please provide details as to the reason why you need to be out longer. You may write down the provider's response below:

_____

_____

Check all areas that your family member will need assistance with:

☐ Personal Hygiene

☐ Cleaning

☐ Dressing

☐ Transportation

☐ Bathroom Needs

☐ Preparing Meals

☐ Other_____

Please bring this the day of your scheduled appt and discuss with the doctor.

Thank you!