BOSTON SCIENTIFIC CORPORATION

**MEDICAL EVALUATION FORM**

Introduction: Boston Scientific uses this form to evaluate the impact of a medical condition, if any, on an employee’s ability to perform his or her job.  We understand that you, the employee’s physician or treatment provider, may have been asked to provide similar information already in connection with a claim for disability benefits.  However, this form is used by us as the employer for this other purpose, including an evaluation of any work restrictions. A copy of the employee’s job description is enclosed for your review. We appreciate your cooperation in providing the requested information.

**PART I: TO BE COMPLETED BY EMPLOYEE/PATIENT (PLEASE PRINT)**

**Employee Name:** Click here to enter text.

**Last 4 digits of Employee SSN:** Click here to enter text.

**PART II: TO BE COMPLETED BY PHYSICIAN OR TREATMENT PROVIDER (PLEASE PRINT)**

Please fully complete, sign, and return this form to Name, Title, Boston Scientific, Address, by Date. Please do not hesitate to call Name, Title, at Phone Number if you have any questions.

1. Have you treated the employee for any condition(s) or impairment(s) that have or could affect the employee’s ability to perform his/her job?

Yes No

**IF YOUR ANSWER TO QUESTION NO. 1 IS NO, PLEASE GO DIRECTLY TO THE LAST PAGE AND SIGN THE EVALUATION AS REQUESTED. YOU DO NOT HAVE TO COMPLETE THE REMAINING QUESTIONS.**

**IF YOUR ANSWER IS YES, PLEASE BE ADVISED THAT WE ARE SEEKING INFORMATION PERTAINING ONLY TO CONDITION(S) OR IMPAIRMENT(S) AFFECTING OR POTENTIALLY AFFECTING THIS EMPLOYEE’S JOB (SUBJECT TO THE FOLLOWING LIMITATIONS).**

**Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other applicable entities from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by the law. Therefore, we are asking that you not provide any genetic information when responding to this request for information. “Genetic information” includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests and/or any other information relating to the individual’s and/or family genetic information.**

2. For what condition(s) or impairment(s) have you been treating the employee? For mental condition(s) or impairment(s) please include DSM-IV diagnosis if available.

Click here to enter text.

3. What is the expected duration of the condition(s) or impairment(s)?

Click here to enter text.

4. Please identify which job function(s), if any, the employee is unable to perform as described and how the employee’s condition(s) or impairment(s) limits his/her ability to perform each such function.

Click here to enter text.

5. Can the employee perform the functions of his/her job without posing significant risk of substantial harm to the health or safety of him/herself or others?

Yes No

If no, please explain your opinion with respect to how the employee’s condition(s) or impairment(s) poses a significant risk of substantial harm to the health and safety of him/herself and/or others.

Click here to enter text.

6. If you are recommending a return to work with restrictions and/or an intermittent leave or a flexible work schedule for this employee, please explain the recommendation(s) with as much specificity as possible (e.g., hours per day, days per week, etc.) and your opinion why this is medically necessary:

Click here to enter text.

7. If the employee is unable to return to work, with or without restrictions, please state when you anticipate that the employee will be able to return to work (e.g., two weeks, not reasonably foreseeable, indefinite, etc.):

Click here to enter text.

8. If the employee has not been released to work or has been released to work with restrictions, please indicate when you will next re-evaluate the employee.

Click here to enter text.

**PART III: SIGNATURE OF ATTENDING PHYSICIAN OR TREATMENT PROVIDER**

I certify that I have reviewed the attached job description provided for the employee and any other information provided by Boston Scientific in conjunction with this evaluation and that the information contained on this form is true and complete to the best of my knowledge and belief.

## Physician/Treatment Provider Name: Click here to enter text.

Medical Specialty: Click here to enter text.

Address: Click here to enter text.

Telephone Number: Click here to enter text. Fax Number: Click here to enter text.

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