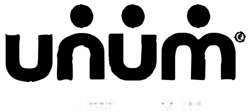

MASSACHUSETTS PAID FAMILY MEDICAL LEAVE REQUEST FORM

Certification of Health Care Provider for Your Own Serious Health Condition

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free 1-866-779-1054 Fax: 1-866-249-3831
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time)

CERTIFICATION OF HEALTH CARE PROVIDER

Patient's Name (Last Name, Suffix, First Name, MI)

Note: If the certification is not completed in English, the employee may be asked to furnish a translation.

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under Massachusetts Paid Family Medical Leave. Answer, fully and completely, all applicable parts, as missing information may cause delays. 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 Massachusetts Paid Family Medical Leave coverage.* Limit your responses to the condition for which your patient is seeking leave.

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 are asking 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 of a fetus carried by an individual or an individual's family member sought or received genetic services, and genetic information or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

MEDICAL FACTS

1. Patient's Name:
2. Date medical condition or need for treatment commenced
3. Is this health condition a job-related injury? ☐ Yes ☐ No
4. If the patient is not the employee, is this health condition related to the patient's military service? ☐ Yes ☐ No
5. When will the employee first need to take leave? (mm/dd/yy)
6. Probable duration of medical condition or need for treatment
7. If the patient's serious health condition is pregnancy related, what is the expected delivery date? (mm/dd/yy)

Page 8 contains a description of what constitutes a "serious health condition" under Massachusetts Paid Family Medical Leave.

8. Does the patient's condition qualify as a serious health condition? ☐ Yes ☐ No
   If yes, please select all that apply to the patient's serious health condition.

   ☐ Hospital Care
   ☐ Absence Plus Treatment
   ☐ Pregnancy
   ☐ Chronic Conditions Requiring Treatment
   ☐ Permanent/Long Term Conditions Requiring Supervision
   ☐ Multiple Treatments (Non-Chronic Conditions)

DATES(S)/TYPE(S) OF TREATMENT

9. a. Indicate the estimated number of treatment(s)/visit(s), and/or estimated duration of medical treatment/visit:
   - Estimated *treatment schedule*: ____times per ______ week(s) ____month(s) ____year(s)
   - Estimated *recovery* for each *treatment:* ____hours or ____day(s) **per** treatment

   b. Is it *medically necessary* for the patient to attend treatments? ☐ Yes ☐ No
10. Provide appropriate medical facts to allow an understanding of how the condition may affect the patient's ability to work. *(Examples may include symptoms, hospitalizations, medical visits, relevant side effects to medication, and referrals for evaluation or treatment.)*

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Patient's Name (Last Name, Suffix, First Name, MI)

Your name: (First Name, MI, Last Name)

LIMITATIONS AND NEED FOR LEAVE CAUSED BY CONDITION (PAST/PRESENT/FUTURE)

11. Answer the following questions for ***full/continuous leave.***

Does this condition cause a ***full/continuous*** period of incapacity? ☐ Yes ☐ No

If inability to perform job function(s) is on an intermittent or reduced basis, see question 12.

If yes, estimate the dates of incapacity,* if end date is unknown please provide a date this should be reevaluated.

From ________ Through ___________

* Incapacity - An inability to perform the functions of one's position, or where the covered individual is a former employee, to perform the functions of one's most recent position or other suitable employment as that term is defined under M.G.L. c. 151A § 25(c), due to the serious health condition, treatment therefor, or recovery therefrom.

12. Answer the following questions for an ***intermittent leave or a reduced work schedule.***

Is it medically necessary for the patient to be off work due to episodic flare-ups on an intermittent basis or to work less than the patient's normal work schedule? ☐ Yes ☐ No

If yes, please provide an estimated frequency and duration below:

Episodic flare ups:

- Estimated *episode frequency*: ____ times per ____week(s) ____month(s) ____year(s)
- Estimated *episode duration*: ____ hours (or) ____ day(s) per flare up

Reduced schedule: ____ hour(s) per day; ____days per week from: _____ through ____.

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes the Healthcare Provider portions of the claim form.

SIGNATURE OF HEALTHCARE PROVIDER/PROFESSIONAL

Signature of Health Care Provider/Professional: **X**	Date of Signature:

Printed name of Health Care Provider/Professional:

Type of medical practice or job title:

Telephone Number: