



CERTIFICATION OF HEALTH CARE PROVIDER

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

INSTRUCTIONS FOR THE EMPLOYEE: Massachusetts Paid Family and Medical Leave permits your employer to require that you submit a timely, complete, and sufficient medical certification to support a request for leave due to your own or family member's serious health condition.

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

Relationship To You: Self Minor child Adult disabled child Parent Spouse Other:

If caring for a family member, briefly describe the care you will provide (check all that apply):

Medical, hygiene, nutritional, or safety needs Transportation Psychological Comfort Other:

Estimated duration and schedule of leave:

Employee Signature

Date Signed

X

INSTRUCTIONS FOR HEALTHCARE PROVIDER: The employee has requested leave under Massachusetts Paid Family and Medical Leave. Answer, fully and completely, all applicable parts as missing information may cause delays.

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.

MEDICAL FACTS

1. Approximate date symptoms/medical condition started:

2. Probable duration of medical condition: or Recurs over an extended period of time

3. Is this health condition a job-related injury? Yes No

4. Is this health condition related to the patient's military service? Yes No

5. Expected/actual delivery date: or Condition not pregnancy

6. If the employee is the patient, 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.)

Page 3 contains a description of what constitutes a "serious health condition" under Massachusetts Paid Family Medical Leave.

7. 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)

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

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

NEED FOR LEAVE DUE TO THE SERIOUS HEALTH CONDITION

8. Is it medically necessary for the employee to work less than their normal work schedule for care/treatment of self or a family member?

Yes No

If yes, provide an estimate of the total amount of leave needed on a continuous and/or intermittent basis:

- a. **Continuous period of incapacity/need for care:** From _____ Through _____
- b. **Medical visits/treatment:** ___ times per week month year, lasting _____ hours days for each appointment, including any recovery period
- c. **Recurring episodes:** ___ times per day week month, lasting _____ hours days
- d. **Reduced schedule:** Employee is able to work ___ hour(s) per day; ___ day(s) per week 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.

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:

Date of Signature:

X

Printed name of Health Care Provider/Professional:

Type of medical practice or job title:

Telephone Number:



SERIOUS HEALTH CONDITIONS

“Serious Health Condition” means an illness, injury (including, but not limited to, on the job injuries), impairment, or physical or mental condition of the employee or a family member of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health conditions may involve one or more of the following:

1. Hospital Care

Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an “inpatient” when the health care facility formally admits him or her to the facility with the expectation that he or she will remain in at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

2. Absence Plus Treatment

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

- (1) Treatment two or more times, in person or via telehealth, by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to pregnancy or for prenatal care.

4. Chronic Conditions Requiring Treatment

A chronic condition which:

- (1) Requires periodic visits, at least two per year, for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).