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Section 3 – Certification of a serious health condition (PFL or PML)
TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER

Name of person applying for leave:

Patient's name: (first name, middle initial, last name)

_____

Patient's date of birth (MM/DD/YYYY)

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Serious Health Conditions

1. If applicable, briefly describe other appropriate medical facts related to the condition(s) or medical diagnosis for which the employee seeks PFML leave.

   (e.g., use of nebulizer, dialysis) _____

2. Date the condition started or will start: _____ (MM/DD/YYYY)

3. Duration of how long the condition lasted or will last: _____

4. Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in the Required Leave Section.

   ❑ **Inpatient Care:** The patient (❑ has been / ❑ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

   ❑ **Incapacity plus Treatment:** (e.g., outpatient surgery, strep throat) Due to the condition, the patient (❑ has been / ❑ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY).

   The patient (❑ was / ❑ will be) seen on the following date(s): _____

   The condition (❑ has / ❑ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g., prescription medication (other than over-the-counter) or therapy requiring special equipment).

   ❑ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ (MM/DD/YYYY).

   ❑ **Chronic Conditions:** (e.g., asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

   ❑ **Permanent or Long Term Conditions:** (e.g., Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

   ❑ **Conditions requiring Multiple Treatments:** (e.g., chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

   ❑ **None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

5. Was medication prescribed for this condition? _____

5. Will the patient be treated 2 or more times per year for this condition? _____

Required Leave Needed

For the medical condition(s) checked in the Serious Health Conditions above, complete all that apply. Several questions require a response as to the frequency/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 PFML coverage.

Treatment Plan:

A) Due to the condition: the patient (❑ had / ❑ will have) planned medical treatment(s) (scheduled medical visits) (e.g., psychotherapy, prenatal appointments) on the following date(s): _____

B) The patient (❑ was / ❑ will be) referred to other health care provider(s) for evaluation or treatment(s).

C) State the nature of such treatments: (e.g., cardiologist, physical therapy) _____

D) Provide your best estimate of the beginning date _____ (MM/DD/YYYY) and end date _____ (MM/DD/YYYY) for the treatment(s).

E) Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery _____ (e.g., 3 days/week)

Leave Schedule

Continuous

A) The patient (❑ was / ❑ will be) incapacitated for a continuous period of time, including any time for treatment(s) and/or recovery.

B) Provide your best estimate of the beginning date _____ (MM/DD/YYYY) and end date _____ (MM/DD/YYYY) for the period of incapacity.

Reduced

A) Due to the medical condition, it is medically necessary for the employee to work a reduced schedule.

B) Provide your best estimate of the reduced schedule the employee is able to work.

From _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

the employee is able to work: _____(e.g., 5 hours/day, up to 25 hours a week)

Intermittent

A) Due to the condition, it (was/is/will be) medically necessary for the employee to be absent from work on an intermittent schedule

B) Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (❑ day / ❑ week / ❑ month) and are likely to last approximately _____ (❑ hours / ❑ days) per episode.

PROVIDER'S INFORMATION AND CERTIFICATION

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition causes an incapacitation from work and that I am a healthcare provider authorized to certify their condition.

Signature: Date:

Name and title:

Certificate license and state: License area/area of practice:

Business name:

Address:

Phone number: Email address: Fax number: