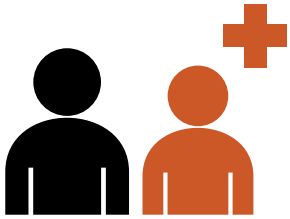
Certification of Your Family Member's Serious Health Condition

Before you apply for paid leave, you must tell your employer that you are applying for paid leave from PFML. Your employer cannot retaliate against you for applying or for taking paid leave. After that, you will be able to submit an application. When you apply, you will need this form. **This form will be shared** with the Department of Family and Medical Leave (DFML), your employer, and employer affiliates.*



This form is required for...

✔ **Leave to care for a family member with a serious health condition** including a family member with a serious health condition related to military service.

This form is not required for...

✖ **Medical leave due to your own serious health condition** or conditions due to pregnancy or post-birth recovery that prevent you from working, as certified by a health care provider.

✖ **Family leave to bond with a child** 12 months after birth, adoption, or foster care placement.

✖ **Active duty leave** to manage family affairs that are related to someone's service in the armed forces.

How to use this form

• Employee

1. Complete **Sections 1 and 2** to tell us about yourself and the family member you need to care for.
2. Write your name at the top of **Pages 5-8**.
3. Give **all 8 pages** of the form to the health care provider who is treating your family member.
4. The health care provider should complete **Sections 3-5** and return the form to you. Benefits will be delayed or denied without certification from a health care provider.
5. Apply for leave at **Mass.gov/paidleave-apply.** Have this **entire completed form** with you when you apply. Some questions in the application refer to this form.
6. Upload the **entire completed form** to your paid leave account at **Mass.gov/paidleave-apply**. You can take a photo of your form or scan it to upload it. If you can't upload the form, fax it to us at **(617)-855-6180**, or call our Contact Center at **(833)-344-7365**.

+ Health care provider (HCP)

1. Review **Page 2** for definitions of key terms.
2. Complete **Sections 3-5** to certify the patient's serious health condition.
3. Initial **Pages 3-7** before you return the form to the employee who is applying for leave.
4. Make sure the patient has provided authorization to share medical information with the employee.
5. Return the **entire form** to the employee whose information is in **Section 1**.

*The information you provide to DFML on this form will be used to administer PFML benefits. In order to process your claim application, and determine your eligibility and benefit amount, DFML shares your information with your current and/or past employer(s), any employer affiliates, and State partners. Visit **Mass.gov/DFML** or call our Contact Center at **833-344-7365** for more information.

Questions? Contact us at **(833) 344-PFML (7365)** or find us online at **Mass.gov/DFML**.

A Definitions of key terms

+ Healthcare provider **Refer to this page** as you fill out the form.

Definition of a serious health condition

A serious health condition could include an illness, injury, impairment or physical or mental condition that involves at least one of the following two conditions:

1. At least one night of inpatient care in a hospital, hospice or residential medical facility
2. Continuing treatment by a health care provider

Inpatient care

An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care.

Continuing treatment

Continuing treatment by a health care provider (plus examples of conditions). Treatment for a condition that fits any of the following descriptions:

A. Any incapacity to work for more than three consecutive full calendar days that also requires medical visits. The patient's first visit must be within seven days of the start of incapacity. Telehealth appointments are also included. These medical visits must meet one of the following two patterns:

- Two or more visits within 30 days of a patient's incapacity to work (unless it is impossible to book two appointments in this time frame).
- One such visit—excluding a routine physical, eye or dental exam—plus a regimen of care or medication under the provider's supervision or prescription. E.g., outpatient surgery or strep throat.

B. Any incapacity due to pregnancy or prenatal care.

C. Any incapacity due to a chronic condition, which is a condition that:

- Requires periodic medical visits,
- Continues over an extended period of time, and
- May cause episodic periods of incapacity that require leave. E.g., asthma or migraine headaches.

D. Any incapacity due to a permanent or long-term condition that may not respond to treatment. E.g., Alzheimer's disease or terminal stages of cancer.

E. Any absence to receive multiple treatments, plus any recovery time, for either of the following:

- Restorative surgery after an accident or injury. E.g., joint replacements or reconstruction.
- A condition that would lead to more than three consecutive days of incapacity if the patient did not receive treatment. E.g., chemotherapy treatments.

Incapacity

An inability to perform the functions of one's job owing to the serious health condition. For unemployed applicants, it means an inability to perform the functions of their most recent position or other suitable employment.

Definition of a health care provider

Health Care Provider:

An individual licensed by the state, commonwealth, or territory in which the individual practices medicine, surgery, dentistry, chiropractic, podiatry, midwifery or osteopathy, and including the following:

A. Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in a state and within the scope of their practice as defined under the law of that state, commonwealth, or territory;

B. Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are within the scope of their practice as defined under the law of that state, commonwealth or territory;

C. Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts;

D. A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is within the scope of practice as defined under such law.

1 Employee Applying for Family Caring Leave

Instructions ▶ Complete **Section 1 and 2**. DFML needs to know your relationship with the family member to certify leave eligibility.

1. **Your name:**

First: Last:

2. **(If different) Your name as it appears on official documents like a driver's license or W-2:**

First: Middle: Last:

3. **Phone #:** ___ – ___ – ____

4. **Date of birth:** mm / dd / yyyy

5. **Last 4 digits of your Social Security Number or Individual Taxpayer ID Number (ITIN):**

6. **Why are you applying for leave?**

- ◯ To care for a family member with a serious health condition
- ◯ To care for a family member with a serious health condition related to military service

If you are applying for your own serious health condition, this is not the correct form. You need the **Certification of Your Serious Health Condition.**

7. **Occupation:**

2 Family member information

Instructions ▶ DFML needs to know your relationship with the patient to certify leave eligibility.

8. **The family member who is experiencing a serious health condition is my:**

- ◯ Child
- ◯ Spouse or domestic partner
- ◯ Parent, or guardian who legally acted as my parent when I was a child
- ◯ Parent of my spouse or domestic partner
- ◯ Sibling
- ◯ Grandchild
- ◯ Grandparent

For more detailed definitions of what family members fall into each of these categories see **www.mass.gov/family-caring-leave-relationships**

9. **Family member's name:**

First: Last:

+ HCP **Initial here to indicate you have reviewed this page:** _____

10 **Family member's name as it appears on official documents such as a driver's license or insurance documents (if different):**

First: Middle: Last:

11 **Family member's address:**

Street:

Address line 2:

City:

State: Zip: Country:

Where your family member lives does not affect your eligibility. You can take paid family leave to care for a family member with a serious health condition no matter where they are.

12 **Family member's date of birth:**

m m / d d / y y y y

13 **Authorization:**

I authorize The Department of Family and Medical Leave (DFML) to use the information on this form to determine my eligibility for Paid Family and Medical Leave. I attest that I am applying for paid leave to care for a family member with a serious health condition, and I agree that DFML can share this information with my employer, and employer affiliates, for the purpose of supporting my application for leave.

I certify that I have the authorization of the above-named family member to provide the information contained within this certification to the Department for purposes of determining my eligibility for paid family leave.

• Employee Signature: <Employee Signature> m m / d d / y y y y

• Employee **Write your name at the top of the remaining pages.**
Afterwards, give this form to your family member's health care provider to complete **Sections 3–5**.

• Employee **Employee applying for leave:** _____

+ Health care provider

Health Care Provider Certification of a Serious Health Condition

3 Family Member's Serious Health Condition

Instructions ▶ This form should be filled out by **the healthcare provider of the patient**. The patient is the family member of the employee. The patient must have a serious health condition for the employee to qualify for paid leave to care for them. Answer all questions fully and completely.

14 **Does the employee's family member (your patient) have a serious health condition as defined by the criteria on page 2?**

◯ Yes ◯ No

◀ If not, then they are not eligible to be taken care of under family leave.

15 **Which of the following criteria from page 2 apply to the patient's serious health condition?**

- ☐ Requires, or did require inpatient care.
- ☐ Has incapacitated or will incapacitate the patient for more than three consecutive full calendar days.
- ☐ Requires two or more medical visits within 30 days.
- ☐ Requires one medical visit, plus a regimen of care.
- ☐ Is chronic, requires treatments at least twice a year, and may require periodic absences.
- ☐ Is long-term and requires ongoing medical supervision, with or without active treatment.
- ☐ Requires multiple treatments and would lead to a period of incapacity without treatment.

◀ Check all that apply.

16 **When did the condition begin?**

Start date: m m / d d / y y y y

◀ If this cannot be determined, provide a start date to the best of your ability.

17 **Is this health condition related to the patient's military service?**

◯ Yes ◯ No

◀ Check only one.

18 **Describe the relevant medical facts and appropriate information related to the condition for which the patient needs care.**

_____

_____

_____

_____

◀ Medical facts may include symptoms, diagnosis, or any regimen of continuing treatment using specialized equipment.

+ HCP **Initial here to indicate you have completed this page:** _____

• Employee **Employee applying for leave:** _____

19 **Will the employee be required to take leave to care for the patient?**

◯ Yes ◯ No

20 **Describe the kinds of care related to the patient's condition that the employee will provide.**

_____

_____

_____

_____

◀ Examples of care may include providing medical, hygienic, nutritional or safety needs that the patient is unable to perform themselves; transportation to the doctor; etc.

4 Estimate Leave Details

Instructions ▶ Provide your best estimate based on your medical knowledge, experience, and examination of the patient. Be as specific as you can be as terms like "unknown" or "indeterminate" may not be enough to approve a claim for paid leave benefits.

21 **During this leave period, which of these patterns of leave do you expect the employee to need as a result of your patient's condition?**

☐ **Continuous leave:**
Completely unable to work for consecutive, uninterrupted days

☐ **Reduced leave schedule:**
A consistent but reduced schedule for multiple weeks

☐ **Intermittent leave:**
Multiple episodes of time off, which may be irregular or unexpected

◀ Check all that apply.

Subsections 4A, B and C: For every leave pattern you selected above, estimate details of that leave below. If the patient's serious health condition requires an extension of the employee's leave, then the employee can submit a new application with a new certification for additional leave needs.

PART 4A - CONTINUOUS LEAVE

Full-time leave taken without interruptions.

22 **How many weeks of continuous full-time leave will the employee require to care for their family member (your patient)?**

_____ Weeks of continuous leave ☐ No continuous leave needed

◀ Use this answer as a guide for entering dates in question 24.

23 **When will the continuous leave period start and end?**

Start date: m m / d d / y y y y **End date:** m m / d d / y y y y

◀ If the patient will need to be re-evaluated for a possible extension, it should be scheduled at least 14 days before the end date to avoid possible delays.

• Employee **Employee applying for leave:** _____

PART 4B - REDUCED LEAVE SCHEDULE

A consistent schedule that is less than the employee's usual schedule.
For example, taking off the same number of hours or days each week.

24 **Not including continuous leave covered in Part 4A, How many weeks of a reduced leave schedule will the employee need to work to care for the patient?**

_____ Weeks of a reduced leave schedule

☐ No reduced leave schedule needed

◀ Use this answer as a guide for entering dates in question 26.

25 **When will the reduced leave schedule start and end?**

Start date: m m / d d / y y y y **End date:** m m / d d / y y y y

◀ If the patient will need to be re-evaluated for a possible extension, it should be scheduled at least 14 days before the end date to avoid possible delays.

26 **How many hours should the employee take off per week during the reduced leave schedule?**

_____ Hours per week ☐ No reduced leave schedule needed

PART 4C - INTERMITTENT LEAVE

Leave taken in separate periods of time due to a single qualifying reason, rather than for one continuous period of time.
For example, leave taken on an occasional basis or several days at a time over a period of months.

27 **When will the intermittent leave schedule start and end?**

Start date: m m / d d / y y y y **End date:** m m / d d / y y y y

◀ If the patient will need to be re-evaluated for a possible extension, it should be scheduled at least 14 days before the end date to avoid possible delays.

28 **Not including any leave covered in Part 4B, on average how often will the patient's condition require the employee to be absent from their job?**

- ○ No other absences expected
- ○ Once or more per week, approximately . . . . . _____ Times per week
- ○ Once or more per month, approximately . . . . . _____ Times per month
- ○ Over the next six months, approximately . . . . . _____ Times total

29 **How long will a single absence typically last?**

- ○ At least one day, up to . . . . . _____ Days.
- ○ Less than one full work day, up to . . . . . _____ Hours.
- ○ N/A, no intermittent leave

◀ In estimating, consider flare-ups, aftercare, consultations, and other effects of the patient's serious health condition.

+ HCP **Initial here to indicate you have completed this page:** _____

• Employee **Employee applying for leave:**

5 Provider's Certification & Information

Instructions ▶ Sign and date to agree to this declaration. Provide the relevant licensing and contact information about your practice or business. Before returning the form to the employee, review to be sure you have initialed **Sections 1–4**.

I certify that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

See **page 2** for the definition of a healthcare provider.

30 **Signature:** Theodore Cure **Date:** m m / d d / y y y y

31 **Printed name and title:**

Name:

Title:

32 **Certificate/license to practice number:** **State/Country:**

33 **Area of practice or medical specialty:**

34 **Name of your practice or business:**

35 **Address:**

36 **Office phone #:** ___ – ___ – ____

37 **Office fax #:** ___ – ___ – ____ (optional)

+ Health care provider

When you have completed and signed the certification, return it to the employee. The employee will submit this information for review by the Department of Family and Medical Leave and their employer.