Certification of Your Serious Health Condition

You are required to notify your employer before submitting an application. Once you have notified your employer, the Department of Family and Medical Leave (DFML) will review all applications to determine your eligibility for benefits. Both the employee who is applying for leave and a health care provider must complete a portion of this form. **This form will be shared** with DFML, your employer, and employer affiliates.*

This form is 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.

This form is not 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.

✖ **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 **Section 1** to tell us about your reason for taking leave.
2. Print your name on **ages 4-7** .
3. Give **all 7 pages** of the form to the health care provider who is treating you. The health care provider will complete **Sections 2-4** and return the form to you. Benefits will be delayed or denied without certification from a health care provider.
4. Apply for leave at **Mass.gov/paidleave-apply.** When you apply you will need this **entire completed form**. Some of the questions in the application will refer to the form.
5. Upload the **entire completed form** to your paid leave account at **Mass.gov/paidleave-apply**. You may need to take a photo of your form or scan it to upload it. If you don't have a way to 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 **age 2** for definitions of key terms.
2. Complete **Sections 2-4** to certify the employee's serious health condition.
3. Initial **ages 3-6** before you return the form to the employee.
4. 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.

A Definitions of key terms

• Employee + Health care 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 Paid Medical Leave

Instructions ► **Complete this section with your own information.** The Department of Family and Medical Leave will use Section 1 to match this certification to the rest of your application for paid leave.

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. **Are you applying for your own serious health condition?**

- ○ Yes
- ○ No

◄ If not, you do not qualify for Medical Leave due to your own serious health condition

7. **Occupation:**

• Employee **Write your name at the top of the remaining pages.**
Afterwards, give this form to your health care provider to complete **Sections 2–4**.

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

+ Health care provider

Health Care Provider Certification of a Serious Health Condition

2 Patient's Serious Health Condition

Instructions ▶ This form should be filled out by the employee's health care provider. For the employee to qualify for paid leave, the patient must have a serious health condition. Answer all questions fully and completely.

8 **Does the patient you're caring for have a serious health condition as defined by the criteria on Page 2?**

◯ Yes ◯ No

◀ If not, the patient is not eligible for PFML.

9 **Which of the following 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.

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.

11 **When did the condition begin?**

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

◀ This is the start of the condition, not the start of the employee's leave from their job. If it cannot be determined, provide a start date to the best of your ability.

• Employee **Employee applying for leave:**

12.A **Is the patient's serious health condition due to pregnancy or prenatal care?**

☐ Yes ☐ No

If yes, expected delivery date: m m / d d / y y y y

During pregnancy, any incapacity due to pregnancy or prenatal care satisfies the continuing treatment requirement for a serious health condition.

12.B **Is the patient's serious health condition due to childbirth or recovery time following birth?**

☐ Yes ☐ No

Post-pregnancy, a serious health condition must involve at least one night of inpatient care by a gestational parent in a hospital, hospice, or residential medical facility; or continuing treatment by a health care provider as defined on page 2.

Taking Medical Leave does not impact an employee's ability to take Family Leave to bond with their child provided that the number of weeks taken for leave does not exceed the 26-week maximum in a benefit year. Family Leave for bonding does not require a health care provider form; there is a separate application.

13 **Is this health condition a job-related injury?**

◯ Yes ◯ No

Check only one.

3 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; terms like "unknown" or "indeterminate" may not be enough to approve a claim for paid leave benefits.

14 **During this leave period, which of these patterns of leave do you expect the employee to need as a result of the 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.

Subsections 3A-3C: For every leave pattern you selected above, estimate details of that leave. If a patient's serious medical condition requires an extension of the employee's leave, then the employee can submit a new application with a new certification.

PART 3A - CONTINUOUS LEAVE

Full-time leave taken without interruptions.

15 **During the leave period, how many weeks of continuous full-time leave do you expect the employee will require?**

_____ Weeks of continuous leave ☐ No continuous leave needed

Include any continuous leave that the employee has already taken for this condition. Use this answer as a guide for entering dates in question 16.

16 **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.

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

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

ART 3B - 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.

17 **Not including continuous leave covered in art 3A , how many weeks of a reduced leave schedule will the employee need during the leave period?**

_____ Weeks of a reduced leave schedule ☐ No reduced leave schedule needed

◀ Use this answer as a guide for entering dates in question 18.

18 **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.

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

_____ Hours per week ☐ No reduced leave schedule needed

ART 3C - 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.

20 **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.

21 **Not including any leave covered in arts 3A and 3B , on average how often will the 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

22 **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.

23 **Is your medical opinion that the patient must refrain from working, either partly or completely, between the dates entered in questions 16, 18, or 20?**

○ Yes ○ No

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

• Employee **Employee applying for leave:**

Describe specific activities the patient should refrain from, either partly or completely, between those dates as a result of their serious health condition.

4 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 **ages 3-6** .

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 health care provider.

24 **Signature:** **Date:** m m / d d / y y y y

25 **Printed name and title:**

Name:

Title:

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

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

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

29 **Address:**

30 **Office phone #:** – –

31 **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.