Health Care Provider Certification

Instructions for applying for paid medical leave

Who should use this form

Massachusetts workers should use this form to apply for:

- Medical leave due to your own serious health condition
- Family leave to care for a family member with a serious health condition that is related to military service
- Family leave to care for a family member with a serious health condition (starting July 1, 2021)

If you're taking leave for any of these reasons, you'll need to complete this form with a health care provider as part of your application at paidleave.Mass.gov. You can create an account now or wait until the form is completed.

If you're taking leave for a reason other than a serious health condition, go to Mass.gov/PFML for instructions on how to certify other reasons.

Instructions for the person applying for leave

- ❏ **Complete section 1 to tell us about your reason for taking leave.** List your name at the top of each page and in section 1. If you're applying for family leave, list your family member's name in section 2.
- ❏ **Ask your health care provider to complete sections 3–6.** Your benefits will be delayed or denied without certification from a health care provider.
- ❏ **Upload the completed form to your paid leave account for the fastest response.** Go to paidleave.Mass.gov to log into your account. You will need to take a photo of your form or scan it in order to upload it. If you don't have a way to upload the form, fax it to us at 1-617-777-7777.

Instructions for the health care provider

- ❏ Review the definitions below as defined in 458 CMR 2.02.
- ❏ Complete sections 3–6 to certify the patient's serious health condition. Refer back to the definitions on the next page as needed, including the definition of a health care provider.

Questions?

If you have questions, please contact us at 1-617-466-3950 or find us online at Mass.gov/DFML

Definitions for the health care provider's use in completing the form

Health care provider

In Section 6, the health care provider will attest to meeting this definition.

Health care providers include:

- Individuals licensed by the state to practice medicine, surgery, dentistry, chiropractic, optometry, podiatry, midwifery, or osteopathy
- Nurse practitioners, nurse-midwives, clinical social workers, physician assistants, and medically trained providers (e.g., physical therapists) who are authorized to practice under state law and performing within the scope of their practice as defined by state law

Serious health condition

Question 12 (in Section 3) asks whether the patient's condition meets this definition.

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

- Inpatient care in a hospital, hospice or residential medical facility
- Continuing treatment by a health care provider, including either two medical visits within 30 days of incapacity or one visit plus a regimen of non-routine care or medication
- Chronic conditions requiring periodic visits or intermittent leave for episodic periods of incapacity

For applicants to qualify for paid leave, the health care provider's medical opinion must be that the serious health condition prevents them from performing some or all of their job duties. Or, if a family member is applying for leave, the patient must require their care because of the serious health condition.

Physical exertion level

Question 22 (in Section 4) asks whether the patient can work at their job's exertion level.

We use the U.S. Department of Labor's physical exertion levels as a standard.

Exertion level	Required strength
Sedentary	Sitting most of the time. Exerting up to 10 pounds of force occasionally to move objects or a negligible amount of force frequently.
Light	Walking or standing frequently, using physical controls while sitting or driving, or working at a production rate pace with lighter materials (e.g., clothing). Exerting up to 20 pounds of force occasionally, or up to 10 pounds of force frequently.
Medium	Exerting 20–50 pounds of force occasionally; 10–25 pounds of force frequently; or up to 10 pounds constantly.
Heavy	Exerting 50 to 100 pounds of force occasionally; 25–50 pounds of force frequently; or 10–20 pounds constantly.
Very heavy	Exerting over 100 pounds of force occasionally; over 50 pounds of force frequently; or more than 20 pounds of force constantly.

Health Care Provider Certification

Sections 1 and 2 should be completed by the person who is applying for paid leave benefits. Sections 3-6 should be completed by a health care provider as defined in Massachusetts regulations [458 CMR 2.02]. Apply at **https://paidleave.Mass.gov**

Section 1: Employee applying for paid leave

Instructions: The person applying for paid leave from their own job is the **employee**. **As the employee, 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:
Rob

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

3. Date of birth: 12 / 20 / 1972

4. Last 4 digits of your Social Security Number or Individual Taxpayer ID Number: 0000

5. I am taking leave because of:
- [✔] My own serious health condition
- [ ] A family member's serious health condition that is related to military service
- [ ] A family member's serious health condition of any other kind

Section 2: Patient information

Instructions: The person who has a serious health condition is the **patient**. If the patient is not the same person as the employee, complete Section 2. Otherwise, skip this section.

6. What is your relationship with the patient?
The patient is my _____

7. Patient's name:

8. *(If different)* Patient's name as it appears on official documents such as a driver's license or insurance documents:

9. Patient's address:

10. Date of birth: ___/___/_____

11. Can the employee provide proof of identity for the patient?
An employee may only take leave to care for a family member. The Department of Family and Medical Leave may require the employee to prove who the family member is.
[ ] Yes [ ] No

Write the employee's name at the top of all the remaining pages. Then, give this form to the patient's health care provider to complete Sections 3-6.

Name of employee applying for leave: Francesca Greene

Section 3: Patient's serious health condition

Instructions: The **employee** is the person whose name is at the top of this page. The **patient** is the person you are caring for. Answer all questions fully and completely. Limit the scope of your answers to the condition you are treating the patient for.

12. Does the patient have a serious health condition that necessitates continuing care?
See the cover sheet for a definition and examples of a serious health condition.

[ ] Yes [ ] No

13. When did the condition begin?
This is the start of the condition, not the start of leave from work. If it cannot be determined, provide a start date to the best of your expertise.

[ ] This condition began within the past 12 months. Start date: ___/___/_____
[ ] This condition began more than one year ago.

14. Which of the following characteristics apply to the patient's serious health condition? Check **all** that apply. The condition:

[ ] Requires continuous treatment from me or another health care provider.
[ ] Requires multiple treatments and would lead to incapacity without treatment.
[ ] Is chronic and may require periodic absences to rest, treat, or recover.
[ ] Is long-term and requires ongoing supervision, with or without active treatment.

If any context is necessary for question 14, please provide that here:

15. Is the patient's serious health condition a pregnancy-related issue that results in some level of incapacity prior to giving birth?
This excludes recovery time following birth. If both apply, account for both in Section 4.

[ ] Yes. Expected delivery date: ___/___/_____ [ ] No

16. Is this health condition a work-related injury?

[ ] Yes [ ] No

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

[ ] Yes [ ] No

18. If the patient is *not* the employee, will the patient require care from someone other than a professional health care provider, such as a family member?

[ ] Yes [ ] No

Name of employee applying for leave: Francesca Greene

Section 4: Ability to work

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.

19. Which of these patterns of leave do you expect the employee to need as a result of the patient's condition? Check **all** that apply.

[ ] **Continuous leave:** Completely unable to work for consecutive, uninterrupted days
[ ] **Reduced leave schedule:** A consistent but reduced schedule for multiple weeks
[ ] **Intermittent leave:** Time off at irregular intervals for flare-ups, aftercare, consultation, or other effects

20. When will the employee first need to take leave?
This is the first day of missed work, regardless of whether it is a partial or a full day. If any work has already been missed because of this condition, enter the earliest missed day.
Start date: ___/___/_____

21. When is the last day the employee will need leave? OR If you cannot determine this, when do you recommend re-evaluating the patient's condition? This must be within six months of the start date.
If the condition requires additional leave after six months or a re-evaluation, the employee can submit a new application at that time with a new health care provider certification.
End/re-evaluation date: ___/___/_____

If the patient is also the employee, answer questions 22–25. **Otherwise**, skip to Section 5.

22. What is the physical exertion level of the patient's job?
[ ] Sedentary [ ] Light [ ] Medium [ ] Heavy [ ] Very heavy
See the cover sheet for the U.S. Department of Labor definition of these categories.

23. Is your medical opinion that someone with the patient's condition must refrain from work at this level of exertion, either partly or completely, between the dates for questions 20 and 21?
[ ] Yes [ ] No

24. During this time, are there any other potentially work-related activities the patient should refrain from, either partly or completely? For example: looking at a bright screen, extended sitting, etc.
[ ] Yes, there are other activities to avoid.
[ ] No, work activities that are not considered exertion are fine.

25. Describe specific work the patient should refrain from, either partly or completely, between the dates for questions 20 and 21.
If a patient needs to be absent from work for treatment, state that this is necessary. If the patient could otherwise be present at work for part of their leave period, describe work they cannot perform.

Name of employee applying for leave: Francesca Greene

Section 5: Estimated leave period

Instructions: All questions in this section refer to the period of time between the dates in questions 20 and 21 above. That date range is the **leave period**.

Estimate the leave time for each type of leave you expect the patient to need. A patient who exceeds the leave estimate, either during or after the leave period, can submit a new application with a new health care provider certification for their additional leave needs.

Continuous leave

26. During the leave period, how many weeks of continuous full-time leave from work do you expect the employee will require?
Continuous leave is full-time leave taken without interruptions. If there is a gap between days of leave, it is not continuous leave. In answering this question, include any continuous leave that the employee has already taken for this condition. For partial weeks, round up.

[ ] _____ weeks of continuous leave.
[ ] I do not recommend any continuous leave.

Reduced leave schedule

27. Not including continuous leave covered in question 26, how many weeks of a reduced leave schedule will the employee need?
A reduced leave schedule is a consistent schedule over multiple weeks that is less than the employee's usual schedule. For example, taking off some hours or days each week. Include any medically necessary travel time in your estimate.

[ ] _____ weeks of a reduced leave schedule
[ ] No reduced leave schedule needed

28. How many hours should the employee's schedule be reduced for each week of the reduced leave schedule? _____ hours

Intermittent leave

29. Not including any leave covered in questions 26 and 27, on average how often will the condition require the employee to be absent from work?
In estimating, consider flare-ups, aftercare, consultations, and other effects of the patient's serious health condition.

[ ] No other absences expected
[ ] Once or more per week, approximately ____ times per week
[ ] Once or more per month, approximately ____ times per month
[ ] Irregularly over the next six months, approximately ____ times total

30. How long will a single absence typically last?

[ ] No more than one full work day, up to ____ hours.
[ ] More than one day, up to ____ days.

Name of employee applying for leave: Francesca Greene

Section 6: Provider's certification and information

Instructions: Sign and date to agree to this declaration. Provide the relevant licensing and contact information about your practice or business.

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition meets the definition of a serious health condition, and that I am a health care provider authorized to certify their condition. [458 CMR 2.02]

Signature:	**Date:**
Printed name and title:	
Certificate license and state:	
License area, area of practice, or specialty:	
Business name:	
Address:	
Phone number:	
Email address:	