# Certification of Your Family Member's 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 your application 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, employer affiliates, and state partners.

## 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 Family Leave to...

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

✖ **Bond with a child** within 12 months after birth, adoption, or foster care placement.

✖ **Manage affairs** for a family member who is an active service member.

## How to use this form

### • Employee

1. Complete **Section 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 5-7.**
3. Give **all 7 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 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 **Page 2** for definitions of key terms.
2. Complete **Sections 3-5** to certify the patient's serious health condition.
3. Make sure the patient has provided authorization to share medical information with the employee.
4. Sign and return the **entire form** to the employee whose information is in **Section 1.**

# 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

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. Your 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** with your own information.

1. Your name:

First: Last:

2. (If different) Your name as it appears on official documents like a driver's license or W2:

First: Middle: Last:

3. Phone #: ___ - ___ - ____

4. Date of birth: __ __ / __ __ / __ __ __ __ (m m / d d / y y y y)

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 our Serious Health Condition**

7. Occupation: _____

8. Optional: NTN - _____ - ABS - 01

Including the application claim number may help your application be processed more efficiently. If you plan on having your healthcare provider submit this form on your behalf, please ensure that you have started your application at paidleave.mass.gov and received your claim number.

# 2 Family member information

**Instructions - Complete Section 2** with your family member's information. DFML needs to know your relationship with the patient to certify leave eligibility.

9. **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
- ◯ Grandparent
- ◯ Grandchild

For more detailed definitions of what family members fall into each of these categories see Family Caring Leave Relationships

10. Family member's name:

First: Last:

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

First: _____ Middle: _____ Last: _____

**12** Family member's address:

Street: _____

Address line 2: _____

City: _____

State: _____ Zipcode: _____ County: _____

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

__ __ / __ __ / __ __ __ __
m m d d y y y y

**14** 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: _____ __ __ / __ __ / __ __ __ __
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.

**15** **Which of the following apply to the patient's serious health condition?** Check all that apply; this includes mental health.

- ☐ Requires, or did require inpatient care.
- ☐ Has incapacitated or will incapacitate the patient for more than three consecutive full calendar days, **AND** (pick one)
  - ○ Requires two or more medical visits within 30 days.
  - **OR**
  - ○ 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.
- ☐ None of the above.

◂ If **none** apply to the patient, the employee is **not** eligible for PFML

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

○ Yes ○ No

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

_____

_____

_____

_____

◂ Medical facts may include symptoms, prescriptions, or referrals for evaluation or treatment.

**18** Will the employee be required to take time off work to care for the patient?

○ Yes ○ No

**19** **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, e.g. transportation to the doctor.

• Employee **Employee applying for leave:**

✚ Health Care Provider

# 4 Estimate Leave Details

**Instructions -** The following questions are about the frequency or duration of a condition. Check all that apply to the patient's condition but you must provide your best estimate of the start and end dates and the duration based on your medical knowledge, experience, and examination of the patient.

20 ☐ **Continuous Leave:** Due to the condition, the patient is/will be incapacitated for a continuous period of time (completely unable to work for consecutive, uninterrupted days).

Provide your **best estimate** of the beginning date _____ **(mm/dd/yyyy)** and end date _____ **(mm/dd/yyyy)** for the period of incapacity.

**Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.**

21 ☐ **Reduced Leave:** Due to the condition, it is medically necessary for the patient to work a reduced but consistent schedule.

Provide your **best estimate** of hours that the patient **should take off** per week during the reduced leave schedule. From _____ **(mm/dd/yyyy)** to _____ **(mm/dd/yyyy)** the patient is not able to work: **(e.g., 5 hours/day, up to 25 hours a week)** _____.

**Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.**

22 ☐ **Intermittent Leave:** Due to the condition, it is medically necessary for the patient to be absent from work on an intermittent basis (multiple episodes of time off, which may be irregular or unexpected). Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

From roughly _____ **(mm/dd/yyyy)** to _____ **(mm/dd/yyyy)** (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.

**Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.**

• Employee **Employee applying for leave:**

✚ Health Care Provider

## 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 signed it.

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.

23 Signature: _____ Date: __ __ / __ __ / __ __ __ __ (m m / d d / y y y y)

24 Printed name and title:

Name: _____

Title: _____

25 Certificate/license to practice number: _____ State/Country: _____

**Note** ▶ The form will not be accepted unless a license number is provided.

26 Area of practice or medical specialty: _____

27 Name of your practice or business: _____

28 Address: _____

29 Office phone #: ___-___-____

30 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.