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 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...

✔ **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 Family 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.

✖ **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** to tell us about your reason for taking leave.
2. Print your name on **Pages 4-6.**
3. Give **all 6 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 **Page 2** for definitions of key terms.
2. Complete **Sections 2-4** to certify the patient's serious health condition.
3. Sign and date form on **Page 6** to attest to the information provided.
4. Return the **entire form** to the patient 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 Paid Medical Leave

Instructions - Complete this section with your own information. The DFML 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 W2:

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. Occupation: _____

7. 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.

• 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 **Your Name:**

✚ 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 **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, the patient is **not** eligible for PFML

9 **Provide appropriate medical facts about the patient's serious health condition** (*e.g., symptoms, prescriptions, referrals for evaluation or treatment*):

10 **State at least one essential job function the patient is unable to perform due to their serious health condition** (*e.g., specific tasks like sitting at a computer, performing manual labor, making decisions, or the ability to work at all*)

11 Is this serious health condition a job-related injury?

◯ Yes ◯ No

12 Is the patient's serious health condition related to pregnancy or recovery from childbirth?

◀ Medical leave for pregnancy, prenatal care, or recovery from childbirth must meet the definition of a serious health condition.

Taking Medical Leave does not impact a patient'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. **There is no form needed to take family leave to bond with a child- just proof of birth.** Learn more.

◯ Yes ◯ No

If **yes**, how much time will the patient need?

- The patient will need approximately ____ weeks for pregnancy or prenatal care
- The patient will need approximately ____ weeks for recovery from childbirth or postnatal care.

13 When is the expected delivery date: __ __ / __ __ / __ __ __ __
m m / d d / y y y y

• Employee **Your Name:** _____

✚ Health Care Provider

3 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.

14 ☐ **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.

15 ☐ **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.

16 ☐ **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 **Your Name:** _____

✚ Health Care Provider

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, **review Pages 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.

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

18 Printed name and title:

Name: _____

Title: _____

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

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

20 Area of practice or medical specialty: _____

21 Name of your practice or business: _____

22 Address: _____

23 Office phone #: ___-___-____

24 Office fax #: ___-___-____ (optional)

✚ Health Care Provider

When you have completed and signed the certification, return it to your patient. The patient will submit this information for review by the DFML and their employer.