Employee Name: _____

Certification of Health Care Provider for Family Member's Serious Health Condition

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

The Connecticut Family and Medical Leave Act (CTFMLA) provides that an employer may require an employee seeking CTFMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. The employer must give the employee **at least 15 calendar days** from receipt of the form to provide the certification. If the employee fails to provide a complete and sufficient medical certification, the CTFMLA leave request may be denied. Information about the CTFMLA may be found at https://portal.ct.gov/DOLUI/newfmlaguidance.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the CTFMLA regulations**. Additionally, you **may not** request a certification for CTFMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date the form is received, unless it is not feasible despite the employee's diligent, good faith efforts. The employee must contact the employer if he/she needs additional time.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The CTFMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for CTFMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the CTFMLA protections. **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** Failure to provide a complete and sufficient medical certification may result in a denial of your CTFMLA leave request. If you need additional time to submit this form, you must contact your employer.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent or Spouse's Parent
☐ Child (of any age) ☐ Grandparent or Spouse's Grandparent
☐ Grandchild ☐ Sibling or Spouse's Sibling
☐ Person related by blood or affinity whose close association with you is equivalent to one of the above-listed relationships

The terms child and parent include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take CTFMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take CTFMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐Transportation
☐ Physical Care ☐Psychological Comfort ☐Other: _____

Employee Name: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work.
From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ hours a day for _____ (*days per week).*

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, **complete all relevant parts of this Section**, and sign the form below. A family member of your patient has requested leave under the CTFMLA to care for your patient. The CTFMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for CTFMLA leave to care for a family member with a serious health condition. For CTFMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the CTFMLA, see the chart at the end of the form.

You should provide other appropriate medical facts including symptoms or any regimen of continuing treatment such as the use of specialized equipment, but you are not required to provide a diagnosis.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (____) _____ Fax: (____) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking CTFMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For CTFMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: *(mm/dd/yyyy)* _____
Provide your **best estimate** of how long the condition lasted or will last: _____

(3) For CTFMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient.

_____

(*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)*

(4) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B. (see "Definitions of Serious Health Condition" chart at the end of the document for more detailed explanation)

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g., outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for ***more than*** three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy).*
The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g., prescription medication (other than over-the-counter) or physical therapy)*

Employee Name: _____

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g., asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long-Term Conditions**: *(e.g., Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g., chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, no additional information is needed. Go to page 4 to sign and date the form.

(5) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks CTFMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits and protections of the CTFMLA apply.

(1) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(2) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).
State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____
Provide your **best estimate** of the beginning date _____ and _____ end date *(mm/dd/yyyy)* for the treatment(s).
Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____
(e.g. 3 days/week)

(3) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.
Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(4) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.
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.

Signature of Health Care Provider: _____ **Date** _____ *(mm/dd/yyyy)*

Employee Name: _____

Definitions of a Serious Health Condition

Inpatient Care

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- Two or more in-person or telemedicine visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- At least one in-person or telemedicine visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.

Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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