MASHANTUCKET EMPLOYMENT RIGHTS OFFICE (MERO)

# Certification of Health Care Provider for Employee's Serious Health Condition

For leave under Title 51, the Mashantucket Pequot Family and Medical Leave Law (MFML Law)

The Mashantucket Pequot Family and Medical Leave Law (MFML Law) provides that an employer may require an employee seeking MFML Law protections for leave due to their own serious health condition to submit a medical certification issued by the employee's health care provider. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide a complete and sufficient medical certification, their leave request under the MFML Law may be denied. Additional information about the MFML Law may be found at MERO.mptn-nsn.gov.

## SECTION I – EMPLOYER OR EMPLOYEE TO COMPLETE

Either the employee or the employer may complete Section I. Use of this form is optional, but 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 MFML Law or regulations. You may not request a certification for leave under the MFML Law 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 created for MFML Law purposes as confidential medical records in separate files from the usual personnel files and in accordance with the strictest confidentiality requirements of applicable law.

| **1.1. EMPLOYEE NAME:** | **1.2. DATE CERTIFICATION REQUESTED:** |
|---|---|
| **1.3. EMPLOYER NAME:** | **1.4. DATE CERTIFICATION MUST BE RETURNED:** |

*The employee must be allowed at least 15 calendar days from the date they receive this form to return the certification, unless it is not feasible despite the employee's diligent, good faith efforts. The employee should contact the employer before the date the certification must be returned if they need additional time to submit a completed certification.*

| **2.1. EMPLOYEE'S JOB TITLE:** | **2.2. JOB DESCRIPTION ATTACHED?** ☐ YES ☐ NO |
|---|---|

**2.3. EMPLOYEE'S REGULAR WORK SCHEDULE:**

**2.4. STATEMENT OF EMPLOYEE'S ESSENTIAL FUNCTIONS:** *(as determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier)*

## SECTION II – HEALTH CARE PROVIDER TO COMPLETE

Please provide your contact information, complete all relevant parts of this Section II, sign the form and return the completed form to your patient. Please type or print legibly to avoid delays in processing your patient's request.

**3.1. HEALTH CARE PROVIDER'S NAME:**

**3.2. HEALTH CARE PROVIDER'S BUSINESS NAME AND ADDRESS:**

**3.3. TYPE OF PRACTICE/MEDICAL SPECIALTY:**

| **3.4. TELEPHONE NUMBER:** | **3.5. FAX NUMBER:** |
|---|---|

**3.6. E-MAIL ADDRESS:**

**Information for Health Care Provider**

Your patient has requested leave from work under the MFML Law due to their serious health condition. The MFML Law allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for leave due to the employee's serious health condition.

For MFML Law 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. **"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. For more information about the definitions of a serious health condition under the MFML Law, see the chart on page 4.

Limit your response to the medical condition(s) for which the employee is seeking leave from the employer under the MFML Law. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **Please fully and legibly complete Part A, which requests medical Information to support the leave request, and Part B, which requests information about the amount of leave needed.** An incomplete or insufficient certification may result in your patient's request for leave being delayed or denied.

## PART A: Medical Information

**A.1.** Please state appropriate medical facts that support your patient's "serious health condition" requiring leave from work. Facts may include, without limitation, information about symptoms, hospitalizations, visits with health care professionals, use of specialized equipment, etc. A diagnosis may be provided, but is not required. The medical facts must be sufficient to support the need for leave from work. _____

_____

_____

_____

_____

_____

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_____

**A.2.** State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

**A.3.** Provide your best estimate of how long the condition lasted or will last: _____

**A.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" at the end of the document for more detailed explanation of the terms below).

☐ **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) *(mm/dd/yyyy)*: _____

_____

☐ **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) *(mm/dd/yyyy)*: _____

_____

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).

☐ **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. Please go to page 4 to sign and date the form.

## PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply below. 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 coverage under the MFML Law.

**B.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) *(mm/dd/yyyy)*: _____

_____

**B.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 treatment(s): (e.g., cardiologist, physical therapy) _____

_____

Provide your **best estimate** of the beginning date_____ *(mm/dd/yyyy)* 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) _____

**B.3.** Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work.

From _____*(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work

_____(e.g., 5 hours/day, up to 25 hours a week).

**B.4.** 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.

**B.5.** Due to the condition, it ☐ was ☐ is ☐ will be medically necessary for the employee to be absent from work 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.

**PART C: Job Description**

The information in Section I may be used to answer the question below. If the employer fails to provide a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be "not able" to perform the essential job functions of the position during the absence for treatment(s).

**C.1.** Due to the condition, the employee ☐ was not able ☐ is not able ☐ will not be able to perform one or more of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

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

**DO NOT SEND COMPLETED FORM TO THE MERO. RETURN TO THE PATIENT.**

**DEFINITIONS OF SERIOUS HEALTH CONDITION**

**SERIOUS HEALTH CONDITION**

**"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.**

**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 (3) consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- Two (2) 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 (7) days of the first day of incapacity; or,
- At least one (1) in-person or telemedicine visit to a health care provider for treatment within seven (7) days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider.

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 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 (3) consecutive, full calendar days if the patient did not receive the treatment.

**INCAPACITY**

"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.