Mashantucket Pequot Tribal Nation

MASHANTUCKET EMPLOYMENT RIGHTS OFFICE (MERO)

Certification of Health Care Provider for Family Member'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 leave under the MFML Law 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 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

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.

SECTION II – EMPLOYEE TO COMPLETE

Please complete and sign Section II before providing this form to your family member or their health care provider. The MFML Law allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for leave due to your family member's serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of the MFML Law 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 request for leave under the MFML Law. Contact your employer if you need additional time to submit this form.

2.1. Name of family member for whom you will provide care: _____

2.2. Please complete the sentence. The family member for whom I am needed to provide care is my…

- ☐ **Spouse –** Partner by marriage or civil union that is legal in the jurisdiction in which it was performed.
- ☐ **Child (of any age) –** Biological, adopted, or foster child, stepchild, TMDC*, legal ward, or a child to whom I now stand *in loco parentis*** or to whom I stood *in loco parentis*** when they were under the age of 18.
- ☐ **Grandchild –** related to me by blood, marriage, adoption by my child, in foster care with my child or a TMDC* of my child.
- ☐ **Parent –** My or my spouse's biological parent, adoptive parent, stepparent, parent-in-law, foster parent, or legal guardian, or a person standing *in loco parentis*** to my spouse or me currently or when we were under the age of 18.
- ☐ **Grandparent -** related to me by blood, marriage, my adoption as a minor child by their child, my foster care by their child or my being a TMDC* of their child.
- ☐ **Sibling –** my or my spouse's biological, half, step, adopted or foster sibling, sibling-in-law or TMDC* sibling.

***TMDC means Tribal Member Dependent Child -** a person who is not a member of the Mashantucket Pequot Tribal Nation (MPTN), who was in the custody and care of a member of MPTN and resided in the household of the Tribal Member as a member of their family for at least seven (7) years on or before reaching the age of 18.

****In loco parentis*** means a relationship in which a person assumes the obligations of a parent to a child, such as the day-to-day responsibilities to care for or financially support a child. No biological or legal relationship is required.

2.3 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:_____

2.4 Give your best estimate of the amount of leave needed to provide the care described (e.g., 2 weeks continuous; 1 day every week for 6 weeks): _____

_____

2.5 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 per day for _____days per week.

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

SECTION III – HEALTH CARE PROVIDER TO COMPLETE

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

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

A family member of your patient has requested leave from work under the MFML Law to care for your patient. 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 under the MFML Law to care for a family member with a 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.

Please 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 a delay or denial of the leave request.

PART A: Medical Information

A.1. Please state appropriate medical facts that support your patient's need for care due to their "serious health condition." 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.

_____

_____

_____

_____

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)

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

B.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 six (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)*

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.