dc paid family leave

FAMILY LEAVE MEDICAL CERTIFICATION FORM (PFL-FMC)

INSTRUCTIONS FOR CLAIMANT:

Use this form to file for Family Leave benefits with the DC Office of Paid Family Leave. This form is used to determine whether your family member has a "serious health condition" as defined by DC's Paid Leave law and whether your family member requires your care or companionship. You must complete the first part of the form, which asks for information about you (the claimant) and your family member. The doctor or licensed health care provider who is treating your family member must complete the second part of the form. You may complete the filing process for Family Leave benefits only after this form is completed and signed by your family member's doctor. Using the online Paid Family Leave benefits portal available at **does.pflbas.dc.gov**, you will be prompted by the system to upload this form at the appropriate place in the filing process.

SECTION 1 (To be completed by the claimant before section 2)

Last Name	First Name	Middle Name

Date of Birth (MM/DD/YYYY) _____ /_____ /_____	Social Security Number or Individual Tax Identification Number (ITIN)

INFORMATION ABOUT THE CARE TO BE PROVIDED TO CLAIMANT'S FAMILY MEMBER

Name of the family member for whom the claimant will provide care

Last Name	First Name	Middle Name

Relationship of family member to claimant:

Describe the nature of the care or companionship the claimant will provide to the family member.

_____

_____

_____

_____

☐ I certify that the information I have provided on this form is true and complete.

Signature: _____ Date: _____

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SECTION 2 (To be completed by the licensed health care provider)

INSTRUCTIONS FOR HEALTH CARE PROVIDER:
The family member of your patient is requesting Paid Family Leave benefits from the District of Columbia in order to provide care or companionship to your patient. The purpose of this form is to determine whether the family member of your patient is eligible for Family Leave benefits under the Paid Family Leave law. Several of the following questions require yes-or-no responses followed by dates, if applicable. Eligibility for benefits depends on the specific circumstances. Answering "Yes" to every question is not necessary for the claimant to be eligible for benefits.

HEALTH CARE PROVIDER INFORMATION

All fields are required, except where noted

Last Name	First Name	Middle Name

Mailing Address — Street / City / State / Zipcode

Telephone Number | Email Address

Type of Practice / Medical Specialty

License Number | National Provider Identifier (Optional)

INFORMATION ABOUT THE PATIENT'S HEALTH CONDITION

Name of the diagnosis or a statement of symptoms of the health condition

_____

_____

Primary ICD-10 Code for Health Condition _____

Secondary ICD-10 Code (Optional) _____

Date Health Condition was Diagnosed

_____
(MM/DD/YYYY)

Yes ☐ No ☐ 1. Is the health condition pregnancy?

_____ If yes, what is the expected delivery date?
(MM/DD/YYYY)

Yes ☐ No ☐ 2. Do you believe your patient has or had an inability to work, attend school, or perform other activities of daily living due to the health condition or to receive treatment for the health condition?

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Yes No

☐ ☐ 3. Is there a date of expected (or actual) recovery from the health condition?

_____ (MM/DD/YYYY)

If yes, what is the date of expected (or actual) recovery for the health condition?

If no, is recovery not ever expected, or is recovery expected but the date unknown?

☐ Not expected ☐ Expected but unknown

Yes No

☐ ☐ 4. Did your patient require inpatient care at a hospital, hospice, or residential medical care facility lasting at least one overnight period to treat this health condition?

If yes, what were the dates of inpatient care?

_____

Yes No

☐ ☐ 5. Did this health condition cause a period of continuous incapacity of your patient lasting at least three (3) full consecutive days?

If yes, what were or are the dates of incapacity caused by this health condition or the need to receive treatment for this health condition?

_____

Yes No

☐ ☐ 6. Did the patient or will the patient require follow-up treatment appointments for this condition?

If yes, what is the current treatment schedule?

_____

_____

_____

_____

Yes No

☐ ☐ 7. Is this health condition a chronic health condition?

Yes No

☐ ☐ If yes, do you expect the patient to experience unpredictable episodes of the underlying condition that cause episodic inability to work, attend school, or perform other activities of daily living?

Yes No

☐ ☐ 8. Does the patient require two (2) or more periodic visits annually to treat this health condition?

If yes, what are the scheduled dates for treatment, if any?

_____

_____

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Yes No

☐ ☐ 9. In the absence of treatment, do you expect that this condition would cause a period of continuous incapacity of your patient lasting at least three (3) full consecutive days or result in death?

Yes No

☐ ☐ 10. Does your patient require surgery to restore functional capacity as a result of an accident or other injury?

If yes, what are the current scheduled dates for surgery?

_____

Yes No

☐ ☐ 11. In your medical opinion, do you believe the patient requires care or companionship by the claimant?

Yes No

☐ ☐ 12. In your medical opinion, do you believe that the nature of the care or companionship described by the claimant above in section 1 is reasonable and necessary?

13. Please provide any additional information about the condition and/or treatment.

_____

_____

_____

_____

_____

_____

14. Please explain and add any additional information about the care that is needed.

_____

_____

_____

_____

_____

_____

☐ I certify that I am a licensed health care provider that is treating this patient and the information I have provided on this form is true and complete.

Signature: _____ Date: _____

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