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MEDICAL LEAVE MEDICAL CERTIFICATION FORM (PFL-MMC)

INSTRUCTIONS FOR CLAIMANT:

Use this form to file for Medical Leave benefits with the DC Office of Paid Family Leave. This form is used to determine whether you have a "serious health condition" as defined by the DC Paid Family Leave law. You must complete section 1 of the form. Your doctor or licensed health care provider must complete section 2 of the form. You may complete the filing process for Medical Leave benefits only after this form is completed and signed by your doctor. ***Please ensure that your health care provider completes all parts of section 2 of the form or your claim may be denied.***
You must submit this form 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)

Last Name	First Name	Middle Name

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

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

INSTRUCTIONS FOR HEALTH CARE PROVIDER:

Your patient is requesting Paid Family Leave benefits from the District of Columbia. The purpose of this form is to determine whether your patient is eligible for Medical Leave benefits under the DC Paid Family Leave law. Please complete **Parts A, B,** and **C**. Limit your responses to the medical condition(s) for which your patient is seeking Paid Family Leave benefits. **Please complete all parts of this section or the form will be returned to you for more information.**

A. HEALTH CARE PROVIDER INFORMATION

All fields are required, except where noted

Last Name	First Name	Middle Name

Mailing Address	Street	City	State	Zip code

Telephone Number	Email Address

Type of Practice / Medical Specialty

State License Number	National Provider Identifier (Optional)

B. QUALIFYING MEDICAL 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)

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MURIEL BOWSER, MAYOR

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Check the box for each statement that is applicable to your patient's medical condition.

☐ **Pregnancy**: Your patient's condition is pregnancy.
The expected delivery date is _____ (mm/dd/yyyy).

☐ **Overnight inpatient care**: Your patient was admitted for inpatient care at a hospital, hospice, or residential medical care facility for at least one overnight period to treat this health condition on the following date(s): _____.

☐ **Incapacity plus treatment** (complete numbers **1**, **2**, and **3** below):
1. Your patient's health condition caused a period of continuous incapacity during which your patient was unable to work, attend school, or perform other activities of daily living lasting at least three (3) full consecutive days from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

2. Your patient required (or will require) treatment for this health condition on the following dates:

_____

_____

3. Your patient's condition (☐ has / ☐ has not) resulted in a regimen of continuing treatment under the supervision of a health care provider (e.g., taking prescription medications, attending therapy appointments). The regimen of continuing treatment involves

_____

☐ **Chronic Condition** (complete numbers **1**, **2**, and **3** below):
1. Your patient's condition (☐ is / ☐ is not) a chronic health condition.

2. Your patient (☐ does / ☐ does not) require two (2) or more medical visits annually to treat this health condition.

3. You (☐ expect / ☐ do not expect) your patient to experience unpredictable episodes of the underlying chronic condition that cause episodic inability to work, attend school, or perform other activities of daily living.

☐ **Permanent incapacity**: Your patient is experiencing permanent or long-term incapacity due to the health condition and requires continuing supervision by a health care provider (e.g., Alzheimer's Disease or a terminal-stage cancer).

☐ **Restorative surgery**: Your patient requires restorative surgery to achieve functional (not cosmetic) capacity after an accident or injury and requires multiple such treatments related to the same accident or injury.

☐ **Preventative treatment**: Your patient requires treatments by health care providers on at least two dates in order to avoid the occurrence of a condition that without treatment would cause incapacity for at least 3 full days.

☐ **None of the above.** Your patient's condition does not fall within one of the above categories.

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C. AMOUNT OF LEAVE NEEDED

☐ **Continuous incapacity:** Your patient experienced (will experience) a period of continuous inability to work, attend school, or perform other activities of daily living beginning on _____ (mm/dd/yyyy) and ending on _____ (mm/dd/yyyy) (if in the future, provide your best estimate).

☐ **Planned medical treatments**: Your patient requires planned medical appointments to treat the health condition on the following dates (future or past):

_____

_____

☐ **Intermittent incapacity**: Your patient experienced (will experience) an intermittent inability to work, attend school, or perform other activities of daily living due to the health condition. If known, those dates were (will be):

_____

If unknown, your patient (☐ is / ☐ is not) expected to experience unpredictable episodes or flare ups of the underlying condition that cause episodic inability to work, attend school, or perform other activities of daily living.

Please provide any additional information about your patient's condition or the need for leave.

_____

_____

_____

_____

☐ 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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