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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 part 1 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 part 2 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.

You must submit this form using the online Paid Family Leave benefits portal available at **does.pflbas.dc.gov**. The system will ask you to upload this form during the claim filing process. **Please ensure that the health care provider completes all sections of part 2 or your claim may be denied.**

PART 1 (To be completed by the claimant before part 2)

Last Name	First Name	Middle Name

Date of Birth (MM/DD/YYYY)
_____ /_____ /_____

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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PART 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. Please complete sections **A** through **E**. Limit your responses to the medical condition(s) for which your patient's family member is seeking Paid Family Leave benefits. **Complete all sections of part 2 or the form will be returned to you for more information.**

A. HEALTH CARE PROVIDER INFORMATION

All fields are required, except where noted

Provider Last Name | Provider First Name

Mailing Address Street | City | State | Zipcode

Telephone Number | Email Address

Type of Practice / Medical Specialty

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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B. QUALIFYING MEDICAL CONDITION (continued)

Check the box for each statement that is applicable to your patient's medical condition. ***For each box that you check, provide the required additional information for that statement.***

☐ **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 (required)):

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 (required):

   _____

   _____
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 (required)):

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.

☐ **Stillbirth**: Your patient experienced a stillbirth on the following date:_____ (mm/dd/yyyy).

☐ **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 the condition and/or treatment.

_____

_____

_____

_____

D. NEED FOR CARE OR COMPANIONSHIP

In your medical opinion, your patient (☐ does /☐ does not) require care or companionship by the claimant.

In your medical opinion, the nature of the care or companionship described by the claimant above in part 1 (☐ is / ☐ is not) reasonable and necessary.

Please provide any additional information about the care to be provided by the family member.

_____

_____

_____

E. CERTIFICATION

☐ 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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