State of Connecticut Human Resources

Medical Certificate

Return to Human Resources at:

Agency Name: Southern CT State University *Attn:* Siraje Owen
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Must be submitted within 30 days of foreseeable leave if leave is FMLA qualifying.

Form #: P33B - Caregiver
Revision Effective Date: 1/1/2022

To be used by an employee who is seeking leave to care for a family member with a "serious health condition" under the Family and Medical Leave Entitlements.

EMPLOYEE INFORMATION	Employee's Name	Employee's ID Number
	Employee's Agency:	
	Employee's Job Title:	Department/Unit
	Employee's Phone Number:	Employee's E-mail:
	Name of individual to whom employee will provide care	

INSTRUCTIONS TO THE HEALTH CARE PROVIDER

This form must be executed by a physician or practitioner whose method of healing is recognized by the State.

Provide full, complete, and legible answers to all questions. Several questions seek a response as to frequency and 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 Family and Medical Leave Entitlements.

Limit your responses to the condition for which the patient is being treated. Do not provide information about genetic tests, as defined in 29 C.F.R. §1635.3(f), genetic services, as defined in 29 C.F.R. §1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b).

If additional space is needed, please attach a separate sheet, and identify the question number. Please be sure to sign the form on page 3.

Page 5 of this form describes what is meant by a **"serious health condition" / "serious illness"** under federal FMLA and state family/medical leave.

CAREGIVER RELATIONSHIP

What is the relationship of the patient to the employee?

☐ Spouse
☐ Parent
☐ Spouse's parent *(State FMLA only)*
☐ Child Age of child _____ **
☐ Grandchild *(State FMLA only)*
☐ Grandparent *(State FMLA only)*
☐ Spouse's grandparent *(State FMLA only)*
☐ Sibling *(State FMLA only)*
☐ Sibling-in-law *(State FMLA only)*
☐ An individual related by blood or affinity whose close association with the employee is the equivalent to one of the to one of the above listed family relationships. *(State FMLA only)*

**If the Child is age 18 or older, are they incapable of self-care due to disability ____ Yes ____ No

Provide medical facts supporting this determination:

_____
_____
_____
_____
_____
_____
_____

MEDICAL FACTS

1. Reason for employee's caregiver absence

___ Illness or injury of the family member
___ Incapacity related to family member's pregnancy and childbirth Expected Due Date: _____

Provide medical facts supporting this determination:

_____
_____
_____
_____
_____
_____

2. Approximate date patient's condition commenced: _____

3. Probable duration of the patient's condition: _____

4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ____NO ____YES

   If YES, dates of admission: _____

5. Is it medically necessary for the patient to receive continuing treatment? ____NO ____ YES

   If YES, provide the following information about the treatment:

   - Dates you treated the patient for the condition: _____
   - Will the patient need to have treatment visits at least twice per year due to the condition? ____ NO ___YES
   - Was medication, other than over-the-counter medication, prescribed? ___ NO ___YES
   - Was the patient referred to other health care provider(s) for evaluation or treatment? ____ NO ___YES
   - Describe other relevant medical facts, if any, related to the condition of the patient. Include, as applicable, a description of relevant symptoms, the regimen of continuing treatment or the plan for continuing supervision provided by the health care provider for a condition for which treatment may not be effective.

_____
_____
_____
_____
_____
_____
_____

6. Does the patient require assistance for basic medical or personal needs or safety, or for transportation? ____NO ___YES

   If YES, please describe.

_____
_____
_____
_____

7. Would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ____NO ___YES

If YES, please describe.

_____
_____
_____
_____
_____
_____
_____

LEAVE NEEDED

8. Is it necessary for the employee to be absent from work due to the patient's medical condition, including the need for treatment and recovery? ____NO ____YES

9. Will the patient be incapacitated for a single continuous period ("block leave") due to their medical condition, including any time for treatment and recovery and will the employee need to provide care and comfort to the patient during that time? ____ NO ___ YES

   If YES, estimate the beginning and ending dates the employee needs to provide care and comfort during the period of incapacity:

   Beginning Date: _____ Ending Date: _____

10. Is it medically necessary for the patient to attend follow-up treatment appointments because of the medical condition? ____ NO ____ YES

    If YES, provide the actual or estimated treatment schedule. Include the dates of any scheduled appointments, the time required for each appointment, and any recovery period:

_____
_____
_____
_____
_____
_____
_____
_____

11. Is it medically necessary for the employee to work on a reduced schedule due to the patient's condition? ____NO ____ YES

    If YES, estimate the reduced work schedule needed by the employee:

    _____ hour(s) per day

    _____ day(s) per week

    From _____ through _____

12. Will the patient's condition cause episodic flare-ups periodically? ____NO ____YES

If YES: Is it medically necessary for the employee to be absent from work during the flare-ups? ____ NO ____ YES

If YES, explain:

_____
_____
_____
_____
_____
_____
_____
_____

13. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

- **Frequency:** _____ time(s) every _____ week(s) **OR**

  _____ time(s) every _____ month(s)

- **Duration:** _____ hour(s) per episode **OR**

  _____ day(s) per episode

Name of Physician or Practitioner (*please type or print)*	
Physician or Practitioner License Number	
Address	
Phone Number	Fax Number
Signed *(Physician or Practitioner)*	Date

Definitions of a Serious Health Condition
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 consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: • Two 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 days of the first day of incapacity; or, • At least one in-person or telemedicine visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
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 (or nurse supervised by the 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 consecutive, full calendar days if the patient did not receive the treatment.