Certification of Health Care Provider for Family Member's Serious Health Condition ACGME Caregiver/Medical Leave

The ACGME Caregiver/Medical Leave provides residents/fellows with a minimum of up to 6 weeks of approved medical, parental, or caregiver leave of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, starting the day the resident/fellow is required to report.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification. This form does not need to be completed to bond with a healthy newborn child or a child placed for adoption or foster care.

Employee name (First, Middle, Last):_____

Employer name: _____ Date:_____ (*mm/dd/yyyy*: List date certification requested)

The medical certification must be returned by _____ *(mm/dd/yyyy)*

(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The ACGME Caregiver/Medical Leave allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for the leave due to the serious health condition of your family member. 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 leave request.

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

Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

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:_____

Give your best estimate of the amount of leave needed to provide the care described _____

If a **reduced work schedule** is necessary to provide the care described, please 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) _____(days per week).

Employee Name _____

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

SECTION III – HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the ACGME Caregiver/Medical Leave to care for your patient. The ACGME Caregiver/Medical Leave allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for leave to care for a family member with a serious health condition. For ACGME Caregiver/Medical Leave 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.

You also may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name (Print): _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone Number: (_____) _____ Fax Number: (_____) _____

Email address: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. Note: For ACGME Caregiver/Medical Leave purposes, "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. 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).

Patient's Name: _____

State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

Provide your best estimate of how long the condition lasted or will last: _____

For the ACGME Caregiver/Medical Leave to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort*):

_____

_____

Employee Name _____

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.

☐_ **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): _____

☐ **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) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s):_____

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 therapy requiring special equipment)

☐ **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, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks leave. (e.g., use of nebulizer, dialysis) _____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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 leave coverage.

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): _____

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 treatments: (*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

_____

Employee Name _____

Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ (mm/dd/yyyy) and end date _____(mm/dd/yyyy) for the period of incapacity.

Due to the condition, (☐ 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 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*)

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 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 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.