State of Connecticut Human Resources

# Medical Certificate

Return to Agency Human Resources

| Form # P33B - Caregiver<br>Revision Date: 9/2018 | To be used by an employee who is seeking leave to care for a spouse, child or parent with a "serious health condition" under the Family and Medical Leave Entitlements. |
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|---|---|---|
| **AGENCY INFORMATION** | Agency Human Resources Representative | Agency Name |
| | Agency Address | |
| | Agency Phone Number | Agency Fax Number |
| **EMPLOYEE INFORMATION** | Employee's Name | Employee's ID Number |
| | Employee's Job Title | Department/Unit |
| | 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.

**CAREGIVER RELATIOSHIP**

What is the relationship of the patient to the employee?

| | |
|---|---|
| ____ Spouse | _____ Parent |
| ____ Child under age 18 | _____ Parent-in-law *(state FMLA only)* |

____ Child age 18 or older and incapable of self-care due to a disability

Provide medical facts supporting this determination:

**MEDICAL FACTS**

1. Reason for employee's caregiver absence

| ___ Illness or injury of the immediate family member |
| --- |
| ___ Incapacity related to immediate family member's pregnancy and childbirth<br>Expected Due Date: ___________________ |

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, information about the referral(s) to other health care provider(s), and 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**

1. 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

2. Will the patient be incapacitated for a single continuous period of time ("block leave") due to his/her medical condition, including any time for treatment and recovery? ____ NO ___ YES

   If YES, estimate the beginning and ending dates for the period of incapacity:

   Beginning Date: ______________________ Ending Date: ___________________________

3. 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:

4. 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:

   ________ hours per day

   ________ days per week

   From ________________________ through ___________________________

5. 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:

- 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: _______ times per _____ week OR

    _______ times per _____ month
  - Duration: ________ hours per episode OR

    ________ days 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 |