Capital Area Health Consortium
Request For Family Leave

For information about specific leave entitlements, contact Capital Area Health Consortium

(To be completed by Employee)

Employee Name ______________________________

Residency Department ______________________________

Home Address ____

City____ **State** ________ **Zip Code** ____________________

Employee's Personal Phone No. _____________________________________

Employee's Personal Email ____

REASON FOR LEAVE: Family Leave (to attend to family responsibilities or care for the serious condition of a family member):

___ **Bonding/Parental Leave:**	___ **Caregiver Leave:**	
___ **Birth of child**	___ **Spouse**	___ **Child**
___ **Adoption of child**	___ **Sibling**	___ **Sibling-in-law**
___ **Placement of foster child**	___ **Parent**	___ **Grandparent**
	___ **Spouse's parent**	___ **Spouse's grandparent**
	___ **An individual related by blood or affinity whose close association with the employee is the equivalent to one of the above listed family relationships.**	

Duration of Leave: *(from)* _________________________________ *(to)* _______________________

TYPE OF LEAVE REQUESTED: (Check all that apply)

☐ **Consistent Leave**: A continuous absence for a single qualifying reason (e.g., one month).

☐ **Reduced Schedule Leave**: A leave schedule that changes your normal work schedule for a period of time by reducing the usual number of working hours per workweek or hours per day.

☐ **Intermittent Leave**: Leave taken in separate blocks of time due to a single qualifying reason (not available for bonding/parental leaves).

ACCRUED TIME REQUIREMENT/TAXABILITY OF PAID LEAVE INCOME:

- For Family Leaves, vacation time must be used except for 2 weeks' vacation time that may be reserved (if available at the time of leave).

- FICA and FLI tax are not required on paid leave income and will not be withheld from paid leave income, resulting in higher net leave pay. We will continue to withhold Federal and State tax since leave pay is taxable.

- I understand that all available leaves will run concurrently at all times.

____ ________________

(Employee Signature) **(Date)**

Return the completed form to Capital Area Health Consortium by email to cahcgroup@uchc.edu or fax to (860) 676-1303.

Any other record of medical documentation, such as communication on the healthcare provider's letterhead, can be accepted in place of the certification.

Capital Area Health Consortium
Medical Certification Family Leave
Return to cahcgroup@uchc.edu or by fax to 860-676-1303

CAPITAL AREA HEALTH CONSORTIUM

Must be submitted within 30 days of foreseeable leave if leave is FMLA qualifying.

EMPLOYEE INFORMATION	Employee's Name
	Residency Program:
	Employee's Phone Number:
	Employee's Email Address:
INSTRUCTIONS TO THE HEALTH CARE PROVIDER **This form must be executed by a healthcare provider whose method of healing is recognized by the State.**	This form is used to certify a serious health condition in order to qualify for Connecticut Paid Family and Medical Leave (CT PFML). Qualifying serious health conditions under federal FMLA and state family/medical leave are defined at the end of the document. See the end of the document for eligible healthcare providers recognized by the State.
CAREGIVER RELATIONSHIP	What is the relationship to the employee? ☐ Spouse ☐ Grandparent ☐ Parent ☐ Spouse's grandparent ☐ Spouse's parent ☐ Sibling ☐ Child ☐ Sibling-in-law ☐ Grandchild ☐ 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. Provide medical facts supporting this determination: ____ ____ ____ ____ ____ ____ ____

1. Approximate date patient's condition commenced: ______________________________
2. Probable duration of the patient's condition: ____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ____NO ____YES

   If YES, dates of admission: ____
4. 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.

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   ____
   ____

5. Does the patient require assistance for basic medical or personal needs or safety, or for transportation? ____NO ___YES If YES, please describe.

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6. 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.

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LEAVE NEEDED

7. 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

8. 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: _____________________________

9. 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:

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10. 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 ________________________

11. 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:

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12. 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 healthcare provider (*please type or print)*	
Address	
Phone Number	Fax Number
Signed *(healthcare provider)*	Date

What is Considered a Serious Health Condition?

A serious health condition is an illness, injury or impairment or physical or mental condition that involves inpatient care or continuing treatment.

Inpatient Care is defined as an overnight stay in a hospital, hospice, or residential medical care facility. This includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Note: If surgery is elective and an overnight stay in the hospital is required, leave is covered.

Continuing Treatment by a Healthcare Provider is defined as any one or more of the following:

• **Incapacity and Treatment** — A period of incapacity of more than three (3) consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

• Two or more in-person visits to a healthcare 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 healthcare 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 healthcare provider.

Example: a healthcare provider prescribes a course of prescription medication or therapy requiring special equipment.

• **Pregnancy** — Any period of incapacity due to pregnancy.

• **Chronic Conditions Requiring Treatments** — Any period of incapacity due to or treatment for a chronic serious health condition which:

• Requires periodic visits for treatment by a healthcare provider at least twice a year; and

• Recurs over an extended period of time and may cause episodic rather than a continuing period of incapacity.

Examples: asthma, migraine headaches, diabetes, epilepsy.

• **Permanent/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 healthcare provider.

Examples: Alzheimer's disease; terminal states of cancer; severe stroke.

• **Multiple Treatments (Non-Chronic Conditions)**

○ 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 employee or employee's family member did not receive treatment.

Examples: chemotherapy; physical therapy.

What is NOT Considered a Serious Health Condition?

The following ailments are NOT considered to be a "serious health condition" unless complications develop such that inpatient care or continuing treatment, as defined above, is required:

• routine physical examinations

• common cold

• flu

• earaches

• upset stomach

• minor ulcers

• headaches, other than migraines

• routine dental work or orthodontia problems

• periodontal disease

• cosmetic treatments, such as most treatments for acne or plastic surgery

Note: Restorative dental or plastic surgery after an injury or removal of cancerous growths are serious health conditions provided all the other conditions are met. Mental illness or allergies may be serious health conditions, but only if all the conditions are met.

Substance Abuse: Leave may be taken only for treatment for substance abuse by a healthcare provider or by a provider of healthcare services on referral by a healthcare provider, but not for absences caused by an employee's substance use.

Healthcare Provider Means:

- A doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices,
- A podiatrist, dentist, clinical psychologist, or optometrist authorized to practice in the state and performing within the scope of his or her practice;
- A chiropractor authorized to practice in the state and performing within the scope of his or her practice;
- A nurse practitioner, nurse-midwife, clinical social worker, or physician assistant authorized to practice in the state and performing within the scope of his or her practice;
- A Christian Science practitioner listed with the First Church of Christ, Scientist, in Boston, Massachusetts; or
- Any health care provider from whom the employer or the employer's group health plan's benefits manager will accept a medical certification to substantiate a claim for benefits.