# Capital Area Health Consortium
# Request For Medical Leave

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

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Employee Name _____

Residency Department _____

Home Address _____

City_____ State _____ Zip Code _____

Employee's Personal Phone No. _____

Employee's Personal Email _____

**REASON FOR LEAVE:** (*Check reason)*
*For information about specific leave entitlements, contact Capital Area Health Consortium*

**Medical Leave (to care for your own serious health condition):**

☐ **My own illness or injury**

☐ **Pregnancy/Maternity Leave**

☐ **Bone marrow/organ donation**

**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 the employee's normal work schedule for a period of time by reducing the employee's 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 Medical leaves, vacation and sick 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 and will be paid in accordance per CAHC's paid leave private plan.

_____ _____

**(Employee Signature)** **(Date)**

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

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

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

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

| | |
|---|---|
| **EMPLOYEE INFORMATION** | Employee's Name |
| | Residency Program: |
| | Employee's Phone Number: |
| | Employee's Email Address: |
| **INSTRUCTIONS TO THE HEALTH CARE PROVIDER**<br><br>**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.<br><br>See the end of the document for eligible healthcare providers recognized by the State. |
| **MEDICAL FACTS** | 1. Reason for absence: |

| | |
|---|---|
| ☐ **Employee's illness or injury** | ☐ **Organ donor** |
| ☐ **Pregnancy Incapactiation and childbirth**<br>Expected Due Date: _____ | ☐ **Bone marrow donor** |

2. Approximate date condition started or will start:_____

3. Best estimate of the duration of the condition: _____

4. Was/will 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 by a medical provider? ☐ 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 for which the employee seeks leave. 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. Is the employee unable to perform any of their job functions due to the medical condition (including the need for treatment and recovery)? ☐ NO ☐ YES

If YES, identify the job functions the employee is unable to perform (using the employee's job specification, if provided, as a reference).

_____
_____
_____
_____
_____
_____
_____

**LEAVE NEEDED**

7. Is it medically necessary for the employee to be absent from work due to their medical condition, including the need for treatment and recovery? ☐ NO ☐ YES

8. Will the employee be incapacitated for a single continuous period due to their 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: _____

9. Is it medically necessary for the employee 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:

_____
_____
_____
_____
_____

10. Is it medically necessary for the employee to work on a reduced schedule due to the employee'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 condition cause episodic flare-ups periodically preventing the employee from performing their job functions? ☐ 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:

_____
_____
_____
_____
_____

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 (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 |

## EMPLOYEE RETURN TO WORK CERTIFICATION

The employee's treating healthcare provider must complete this certification.

The employee must provide the completed return to work certification to Capital Area Health Consortium **before** returning to work,

| Employee's Name: | Employee's Job Title: |
|---|---|
| | |

I have examined _____ and certify that they are able to return to work.
(employee's name)

Date the employee will be able to return from leave: _____

Will the employee have any restrictions when they return to work? ☐ NO ☐ YES

If YES, describe the restrictions (If additional space is needed, please attach a separate sheet):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

| 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.*

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## 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 health care services on referral by a healthcare provider, but not for absences caused by an employee's use of the substance.

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**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.