MEDICAL LEAVE MEDICAL CERTIFICATION FORM (PFL-MMC)

INSTRUCTIONS FOR CLAIMANT:

Use this form to file for Medical Leave benefits with the DC Office of Paid Family Leave. This form is used to determine whether you have a "serious health condition" as defined by the DC Paid Family Leave law. You must complete the first part of the form. Your doctor or licensed health care provider must complete the second part of the form. You may complete the filing process for Medical Leave benefits only after this form is completed and signed by your doctor. Using the online Paid Family Leave benefits portal available at **does.pflbas.dc.gov**, you will be prompted by the system to upload this form at the appropriate place in the filing process.

SECTION 1 (To be completed by the claimant)

Last Name	First Name	Middle Name

Date of Birth (MM/DD/YYYY)	Social Security Number or Individual Tax Identification Number (ITIN)
_____ /_____ /________	

SECTION 2 (To be completed by the licensed health care provider)

INSTRUCTIONS FOR HEALTH CARE PROVIDER:

Your patient is requesting Paid Family Leave benefits from the District of Columbia. The purpose of this form is to determine whether your patient is eligible for Medical Leave benefits under the DC Paid Family Leave law. Several of the following questions require yes-or-no responses followed by dates, if applicable. Eligibility for benefits depends on the specific circumstances. Answering "Yes" to every question is not necessary for the claimant to be eligible for benefits.

Address: 4058 Minnesota Ave., NE, Washington, DC 20019 · Phone: 202-899-3700 · Email: PFLBenefitsDivision@dc.gov

DOES District of Columbia Department of Employment Services

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A. HEALTH CARE PROVIDER INFORMATION

All fields are required, except where noted

Last Name | First Name | Middle Name

Mailing Address — Street | City | State | Zip code

Telephone Number | Email Address

Type of Practice / Medical Specialty

State License Number | National Provider Identifier (Optional)

B. INFORMATION ABOUT THE CLAIMANT'S MEDICAL CONDITION

Name of the diagnosis or a statement of symptoms of the health condition

____

____

Primary ICD-10 Code for Health Condition ______________________________

Secondary ICD-10 Code (Optional) ______________________________

______________ (MM/DD/YYYY) Date health condition was diagnosed

Yes No
☐ ☐ 1. Is the medical condition pregnancy?

______________ (MM/DD/YYYY) If yes, what is the expected delivery date?

Yes No
☐ ☐ 2. Do you believe your patient has or had an inability to work, attend school, or perform other activities of daily living due to the health condition or to receive treatment for the health condition?

Yes No
☐ ☐ 3. Is there a date of expected (or actual) recovery from the health condition?

______________ (MM/DD/YYYY) If yes, what is the date of expected (or actual) recovery for the health condition?

If no, is recovery not ever expected, or is recovery expected but the date unknown?

☐ Not expected ☐ Expected but unknown

Yes No
☐ ☐ 4. Did your patient require inpatient care at a hospital, hospice, or residential medical care facility lasting at least one overnight period to treat this health condition?

If yes, what were the dates of inpatient care?

____

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Yes No
☐ ☐ 5. Did this health condition cause a period of continuous incapacity of your patient lasting at least three (3) full consecutive days?

If yes, what were or are the dates of incapacity caused by this health condition or the need to receive treatment for this health condition?

____

Yes No
☐ ☐ 6. Did your patient or will your patient require follow-up treatment appointments for this condition?

If yes, what is the current treatment schedule?

____

Yes No
☐ ☐ 7. Is this health condition a chronic health condition?

Yes No
☐ ☐ If yes, do you expect your patient to experience unpredictable episodes of the underlying condition that cause episodic inability to work, attend school, or perform other activities of daily living?

Yes No
☐ ☐ 8. Does your patient require two (2) or more periodic visits annually to treat this health condition?

If yes, what are the current scheduled dates for treatment, if any?

____

Yes No
☐ ☐ 9. In the absence of treatment, do you expect that this condition would cause a period of continuous incapacity of your patient lasting at least three (3) full consecutive days or result in death?

Yes No
☐ ☐ 10. Does your patient require surgery to restore functional capacity as a result of an accident or other injury?

If yes, what are the current scheduled dates for surgery?

____

Please add any additional information about your patient's diagnosis or condition. (Optional)

____

____

☐ I certify that I am a licensed health care provider that is treating this patient and the information I have provided on this form is true and complete.

Signature: ______________________ Date: ______________________

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