State of Connecticut Human Resources

Medical Certificate

Return to Human Resources at:

Agency Name: _____ *Attn:* _____

E-mail Address: _____ *FAX:* _____

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

Form #: P33A - Employee

Revision Effective Date: 1/1/2022 To be used by employee who is absent for personal illness, including FMLA absences.

EMPLOYEE INFORMATION	Employee's Name	Employee's ID Number
	Employee's Agency:	
	Employee's Job Title:	Department/Unit
	Employee's Phone Number:	Employee's E-mail:

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 employee is or will be absent from work. 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.

Page 5 of this form describes what is meant by a **"serious health condition" / "serious illness"** under federal FMLA and state family/medical leave.

MEDICAL FACTS

1. Reason for employee's absence:

____ **Employee's illness or injury**	____ **Organ donor**
____ **Incapacity related to employee's pregnancy and childbirth** Expected Due Date: _____	____ **Bone marrow donor**

2. Approximate date condition commenced: _____

3. Probable duration of the 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 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 Physician or Practitioner (*please type or print)*	Physician or Practitioner License Number
Address	
Phone Number	Fax Number
Signed *(Physician or Practitioner)*	Date

EMPLOYEE FITNESS-FOR-DUTY CERTIFICATION

The employee's treating health care provider must complete this fitness-for-duty certification.

The employee must provide the completed fitness-for-duty certification to Human Resources **before** reporting to their department or unit.

Employee's Name	Employee's ID Number
Employee's Job Title	Department/Unit

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 Physician or Practitioner (*please type or print)*	Physician or Practitioner License Number	
Address		
Phone Number	Fax Number	
Signed *(Physician or Practitioner)*		Date

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 or telemedicine 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 or telemedicine 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.