City of Duluth Human Resources

218-730-5210 | hrinformation@duluthmn.gov

Room 340 | 411 West First Street | Duluth, Minnesota 55802

www.duluthmn.gov

Caring Leave Certification Form

Submit this form as part of a Caring Leave application if you are taking leave to care for a family member or someone close to you (see **Page 7** for details about who is included) with a serious health condition. You will need to ask your family member's healthcare provider to fill out sections of this form.

Things to keep in mind:

- It is important that the leave dates you and your family member's provider enter match the dates you have told or will tell the City of Duluth Human Resources.

This form has four sections:

1. Applicant/Employee Information (Caregiver)
2. Health Condition Information
3. Leave Information
4. Healthcare Provider Certification

How to complete this form:

This form can be filled out digitally or printed and filled out by hand.

1. Complete the Applicant/Employee Information (Caregiver) section.
2. Give this form to the healthcare provider who is treating your family member. **Page 8** lists the kinds of healthcare providers eligible to complete this form.
3. The healthcare provider will complete the Health Condition Information, Leave Information, and Healthcare Provider Certification sections and return the form to you.
    - Upload the form and submit it with your City of Duluth - Minnesota Paid Leave online application (https://forms.duluthmn.gov/Forms/MNPL).
        - If the form was completed digitally, upload the file directly.
        - If the form was printed, upload a photo or scan of the completed pages.
        - If you cannot upload your form, call Human Resources at 218-730-5210.

1) Applicant/Employee Information (Caregiver)

Instructions: Complete this section with information about the applicant (employee) requiring leave to care for a family member.

1. **Applicant/Employee Legal Name (Caregiver)**

First Name	Middle Name (optional)	Last Name

2. **Employer (select one):**
   - ○ City of Duluth
   - ○ Duluth Airport Authority

3. **Applicant's Date of Birth (MM/DD/YYYY):** _____

4. **The family member you are taking leave to care for is your:**
   - ○ Spouse or domestic partner
   - ○ Child
   - ○ Parent or legal guardian
   - ○ Sibling
   - ○ Grandchild
   - ○ Grandparent or spouse's grandparent
   - ○ Son-in-law or daughter-in-law
   - ○ Someone who has an expectation of and reliance on me to care for them without compensation

5. **What is the legal name of the family member requiring care?**

First Name	Middle Name (optional)	Last Name

By signing, I authorize the healthcare provider who completes this form to confirm with the City of Duluth Human Resources that the information is correct.

I certify that my family member has authorized me to share the information in this form with the City of Duluth Human Resources.

Applicant Signature: _____ **Date Signed (MM/DD/YYYY):** _____

2) Health Condition Information

Must be completed by a healthcare provider.

Instructions: This section should be completed by the healthcare provider of the person (patient) who needs care for their serious health condition. The patient must have a serious health condition, which is defined as an illness, injury, impairment, or condition (including mental health conditions, pregnancy, or substance use disorders) that affects a person's physical health, mental health, or both. **Answer all questions fully and completely. Do not use terms like unknown or TBD.**

1. **Which of the following apply to the patient's serious health condition? (Check all that apply.)**

   ☐ Requires, or did require, inpatient care.

   ☐ The condition is pregnancy or related to pregnancy.

   Expected Delivery Date (MM/DD/YYYY): _____

   ☐ Has incapacitated or will incapacitate the patient for more than seven (7) calendar days in a row AND requires one of the following:

   Select one: ○ Two or more medical visits within 30 days

   ○ One medical visit, plus a regimen of care

   ☐ Is chronic, will continue over time, requires treatment at least twice a year, and may require periodic absences.

   ☐ Is long-term and requires ongoing medical supervision, with or without active treatment.

   ☐ Requires multiple treatments and/or recovery from treatments due to:

   Select one: ○ Restorative surgery after an accident or injury

   ○ A condition that would lead to a period of incapacity without treatment

   ☐ None of the above. **If selected, the patient does not qualify for Paid Leave.**

2. **Approximate date the condition started or will start (MM/DD/YYYY):** _____

3. **Provide your best estimate of how long the condition lasted or will last (e.g., number of years, months, weeks, or days):** _____

4. **If needed, briefly describe other appropriate medical facts related to the condition(s), such as use of nebulizer, dialysis, etc.:**

3) Leave Information

Must be completed by a healthcare provider.

Instructions: Check all that apply given the care needed for the patient's serious medical condition, which is defined as an illness, injury, impairment, or condition (including mental health conditions, pregnancy, or substance use disorders) that affects a person's physical health, mental health, or both.

☐ **Continuous Leave:** The patient requires continuous care for a consecutive number of days. Provide your best estimate of the duration of the period of incapacity:

Start Date (MM/DD/YYYY): _____ **End Date (MM/DD/YYYY):** _____

☐ **Reduced Leave:** The patient requires care on a consistent schedule. Provide your best estimate of the time the patient will be incapacitated per week during the following dates:

Start Date (MM/DD/YYYY): _____ **End Date (MM/DD/YYYY):** _____

- The patient is/will not be able to work _____ (○ hours / ○ days) per week

☐ **Intermittent Leave:** The patient requires care intermittently on a consistent or inconsistent schedule. Provide your best estimate of the frequency and duration of the episodes of incapacity during the following dates:

Start Date (MM/DD/YYYY): _____ **End Date (MM/DD/YYYY):** _____

- Episodes of incapacity are estimated to occur _____ times per (○ day / ○ week / ○ month)
- Episodes of incapacity are estimated to last _____ (○ hours / ○ days)
- Describe how this intermittent leave is medically beneficial to the patient given their medical condition. Your answers should be based on your medical knowledge of and experience with the patient.

3) Leave Information (continued)

Must be completed by a healthcare provider.

Instructions: This section should be completed by the healthcare provider of the person who needs care (referred to as patient) for their serious health condition. The following questions are about the frequency or duration of the patient's condition. **Answer all questions fully and completely. Do not use terms like unknown or TBD.**

1. **Does the patient require care by the applicant requesting leave?**

   Select one: ○ Yes

   ○ No

2. **What type of care does the patient need their family member(s) to provide?**

   ☐ Assistance with basic medical, hygiene, nutrition, mobility, or safety needs

   ☐ Transportation

   ☐ Psychological comfort

   ☐ Other: _____

3. **Please list the legal name of the Applicant/Caregiver:**

_____	_____	_____
First Name	Middle Name (optional)	Last Name

4) Healthcare Provider Certification

Must be completed by a healthcare provider.

Instructions: Provide the relevant licensing and contact information about your practice. Sign and date to certify this leave application. Return the form to the patient or applicant.

1. **Provider's Name**

_____ _____ _____

First Name | Middle Name (optional) | Last Name

2. **Title and Area of Practice or Medical Specialty**

_____

3. **Contact Information**

_____ _____

Office Phone | Office Fax

_____ _____

Office Mailing Address Line 1 | Office Mailing Address Line 2 (optional)

_____ _____ _____

City | State | Zip Code

4. **License or Practice Number** **Form will not be accepted without a license number.**

_____ _____

License or Practice Number | State/Country

By signing below, I certify the following:

- The patient has a serious health condition and requires care.
- The applicant will provide care to the patient that will limit or prevent the applicant from performing regular work.
- I have answered all questions as true and complete to the best of my knowledge, experience, and belief.
- I am a healthcare provider who is licensed, certified, or otherwise authorized under law to certify the patient's condition within my scope of practice.

Provider Signature: _____ **Date (MM/DD/YYYY):** _____

Definition of a Family Member

Someone is a family member if they are:

- a spouse or domestic partner
- a child, including a biological child, adopted child, foster child, stepchild, child of a domestic partner, or child to whom the applicant stands in loco parentis (in the place of a parent), is a legal guardian, or is a de facto custodian (an informal, acting custodian)
- a parent or legal guardian of the applicant or the applicant's spouse
    - *Paid Leave defines "parent" as the biological, adoptive, de facto custodian, or foster parent, stepparent, or legal guardian of an applicant or the applicant's spouse, or an individual who stood in loco parentis to an applicant when the applicant was a child.*
- a sibling
- a grandchild
    - *Paid Leave defines "grandchild" as a child of the applicant's child.*
- a grandparent of the applicant or the applicant's spouse
    - *Paid Leave defines "grandparent" as a parent of a person's parent.*
- an individual who has a personal relationship with the applicant that creates an expectation and reliance that the applicant care for the individual without compensation, whether or not the applicant and the individual reside together.

Definition of a Healthcare Provider

A healthcare provider is an individual who is licensed, certified, or otherwise authorized under law to practice in the individual's scope of practice as a:

- physician, physician assistant, Doctor of Osteopathic Medicine (D.O.)
- nurse practitioner, advanced practice registered nurse, nurse-midwife
- licensed midwife
- dentist
- optometrist
- chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist)
- podiatrist
- surgeon
- advanced practice registered nurse
- clinical psychologist, clinical social worker
- an alcohol and drug counselor as defined by the State of Minnesota
- a mental health professional as defined by the State of Minnesota

A healthcare provider whose certification of a serious health condition would be accepted by the employer or by the employer's health plan benefits manager to substantiate a claim for benefits.

A healthcare provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of their practice as defined under such law.

Any other individual determined by the commissioner by rule, in accordance with the rule-making procedures in the Administrative Procedure Act, to be capable of providing healthcare services.