City of Duluth Human Resources

218-730-5210 | hrinformation@duluthmn.gov

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

www.duluthmn.gov

Medical Leave Certification Form

Submit this form as part of your application for Medical Leave. Medical Leave includes leave to care for your own serious health condition, which is defined as an illness, injury, impairment, condition, or substance use disorder that affects a person's physical health, mental health, or both. You will need to ask your healthcare provider to complete sections of this form.

Note about leave for your pregnancy:

- If you will be taking both continuous Medical Leave due to pregnancy or recovery from birth AND Bonding Leave to bond with your newborn right after recovering from the birth, you must apply for Birth and Bonding Leave and use the Pregnancy-Related Medical Leave Certification Form instead.
- Use this Medical Leave Certification Form if you are applying for Medical Leave for your pregnancy but are not also applying for leave to bond with your new child at this time.

Things to keep in mind:

- It is important that the leave dates you and your healthcare provider enter match the dates you have told or will tell Human Resources.

This form has four sections:

1. Applicant/Employee Information
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 section.
2. Give this form to the healthcare provider who is treating you. **Page 9** 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.

4. To submit your completed form:

   - 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

Instructions: Complete this section with the applicant's information.

1. **Applicant/Employee Legal Name**

   _____ _____ _____

   First Name Middle Name (optional) Last Name

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

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

4. **Phone Number:** _____

5. **To take Medical Leave, your serious health condition must prevent you from completing at least one essential job function. Check the types of job functions you are or will be unable to do:**

   ☐ Physical duties like standing, lifting, climbing, balancing, traveling, commuting, and repetitive motions

   ☐ Cognitive duties like planning, concentrating, writing, decision-making, problem solving, and facilitation

   ☐ Other: _____

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

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 applicant's healthcare provider. To qualify for Paid Leave, the applicant/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) for which the applicant is seeking leave (e.g., use of nebulizer, dialysis).**

2) Health Condition Information (continued)

Must be completed by a healthcare provider.

5. Do you agree that the patient cannot or will not be able to do the type(s) of job duties they indicated in the Applicant/Employee Information section of this medical certification form?

Select one: ○ Yes

○ No

6. Is this serious health condition a job-related injury?

Select one: ○ Yes

○ No

3) Leave Information

Must be completed by a healthcare provider.

Instructions: This section should be completed by the applicant's healthcare provider. The following questions are about the frequency or duration of a condition. Check all that apply to the patient's serious health condition. **Answer all questions fully and completely. Do not use terms like unknown or TBD.**

1. ☐ **Continuous Leave:** Is/will the patient be incapacitated for a continuous period of time and completely unable to work for consecutive, uninterrupted days due to their condition? **If yes, provide your best estimate of the duration of the period of incapacity:**

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

2. ☐ **Reduced Leave:** Is it medically beneficial for the patient to work a reduced, but consistent schedule due to their condition? **If yes, 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): _____

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

3. ☐ **Intermittent Leave:** Is it medically beneficial for the patient to be absent from work on an intermittent basis (multiple episodes of time off, which may be irregular or unexpected) due to their condition? **If yes, 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): _____

   a) Episodes of incapacity are estimated to occur _____ times per (○ day / ○ week / ○ month)

   b) Episodes of incapacity are estimated to last _____ (○ hours / ○ days)

   c) 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.

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 is receiving medical care related to their serious health condition and is unable to perform regular work due to their medical condition or required treatment.
- 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 Serious Health Condition

A serious health condition is an illness, injury, impairment, condition, or substance use disorder that affects a person's physical health, mental health, or both.

A serious health condition must involve at least one of the following:

1. **inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity**
    a. What is inpatient care? An overnight stay in a hospital, hospice, or residential medical care facility. This includes any period of incapacity, or any follow-up treatment resulting from the inpatient care.
    b. What is incapacity? Incapacity happens when a person is unable to perform their job functions because of the serious health condition.

2. **continuing treatment or supervision by a healthcare provider**
    a. What is continuing treatment or supervision? Continuing treatment or supervision by a healthcare provider must include one or more of the following:
        i. seven or more days of incapacity, and any treatment or period of incapacity related to the same condition after the initial timeframe a period of incapacity due to medical care related to pregnancy;
        ii. a period of incapacity or treatment for a chronic health condition;
        iii. a permanent or long-term period of incapacity due to treatment that may not be effective;
        iv. a period of absence to receive multiple treatments; this can include any period of recovery from the treatments. You must receive treatments from your healthcare provider, or someone who provides healthcare services that your doctor ordered or referred to provide treatment.

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