HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

1. Does patient require care by the employee requesting Paid Family Leave(PFL)?

Yes No (If no, skip to "Health Care Provider Information".)

Note: For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

2. Primary ICD-10 code (optional)

3. Diagnosis

4. Date patient's condition commenced (MWDD/YYYY)		
5. First date care for patient is needed (MWDD/YYYY)		
6. Expected date patient will no longer require care		
	Days/week	Days/month
Health Care Provider Information (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)		

