

New York City District Council of Carpenters
Labor Technical College
Apprentice Medical Leave Policy

Certification of Health Care Provider

(Return this form to the Patient)

1. Patient's Name: _____ Patient's
UBC: _____
2. Page 3 describes what is meant by a "serious health condition". Does this patient's condition¹ qualify under any of the categories described? If so, please check the applicable category.
- (1)_____ (2)_____ (3)_____ (4)_____ (5)_____ (6)_____ None of the above
3. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:
4. a. State the approximate date the condition commenced and the probable duration of the condition (and also probable duration of the patient's present incapacity² if different).
- b. Will it be necessary for the patient to take work only intermittently or to work less than a full schedule as a result of the condition (including for treatment described in item 5 below)?
- If yes, give the probable duration:
- c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity².

¹ Here and elsewhere on this form, the information sought relates only to the condition for which the patient is taking leave.

² "Incapacity," for purposes of leave is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

5. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work, school or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known and period required for recovery if any:

b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

6. a. If medical leave is required for the patient's absence from work or school (including absences due to pregnancy or a chronic condition), is the patient unable to perform work of any kind?

b. If able to perform some work, is the patient unable to perform any one or more of the essential functions of that patient's job or training? (The essential functions of the patient's job/training include working with hand tools including hammer and saw, lifting materials, unloading trucks, climbing scaffolds, erecting and dismantling scaffolds). If yes, please list the essential functions the patient is unable to perform:

c. If neither a. nor b. applies, is it necessary for the patient to be absent from work or school for treatment?

Address: _____

Signature of Health Care Provider

Type of Practice: _____

Telephone
Number: _____

Date: _____

Stamp of Health Care Provider

Patient's Signature

A "Serious Health Condition" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity² of more than three calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves"

(1) Treatment³ two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment⁴ under the supervision of a health care provider.

3. Pregnancy

Any period of incapacity due to pregnancy or for prenatal care.

4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider.

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity² (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity² which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

³ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of Incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment such as cancer (chemotherapy, radiation, etc.), severs arthritis (physical therapy), and kidney disease (dialysis).

NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

AUTHORIZATION FORM

For Use of Disclosure of Protected Health Information

PURPOSE OF THIS FORM

Under the Health Insurance Portability & Accountability Act (HIPAA), in order for the Welfare Fund to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information "PHI" is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use of disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund.



Name: _____

UBC# _____



I hereby give permission to the Welfare Fund, or any of its affiliates or agents and their staff performing services in connection with my claim for health plan benefits, to disclose my protected health information (PHI) identified in Section #3 of this Form to the following class persons:

Spouse _____

Employer or the Fund New York City District Council of Carpenters Pension Fund _____

Business Manager, Union Official or Agent _____

Other Person(s) New York County Health Services Review Organization/Med Review _____



I authorize the Welfare Fund to disclose PHI (including written, electronic, or oral information) to the person(s) identified in Section #2 of this form in connection with (mark all that apply): (if you want different people to have access to different information, you must fill out separate forms.)

- Hospital/Medical Claims
- Prescription Drug Claims
- Vision Claims
- Mental Health Claims
- Dental Claims
- Hearing Aid Claims
- Specific claim for health benefits
- Disability Claim information
- Work/Eligibility History

(Describe the event or claims involved with the date of service)

The purpose of the use of disclosure of my protected health information (PHI) is:

NOTE: "at the request of the individual" is a sufficient description of the purpose.

This Authorization form is valid until:

1. _____ (please provide date of event);
2. The date the Fund receives my Cancellation of Authorization Form; or
3. If not otherwise indicated in (1) above, one year from the date I sign this form.

I understand that:

- I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.
- I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TOP THE WELFARE FUND. CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE WELFARE FUND RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.
- THE PERSON(S) I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.
- TREATMENT, PAYMENT, ENROLLMENT AND ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON OBTAINING AN AUTHORIZATION.

Your Signature (or Signature of Personal Representative*) Date

*If you are acting as the personal representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.