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 14 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.

This form has five sections:

1. **Family member requiring care**
2. **Applicant information (caregivers)**
3. **Health condition information**
4. **Leave information**
5. **Healthcare provider certification**

Things to keep in mind

- It is important that the leave dates you and your family member's provider fill in match what you told or will tell your employer.

How to complete this form:

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

1. Complete the applicant information and family relationship sections.
2. Give this form to the healthcare provider who is treating your family member. Page 14 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. There are several ways to get your form to us.
    a. If you have completed this form digitally, you can upload the completed file online at paidleave.mn.gov.
    b. If you printed the form, you can upload photos or a scan of the completed form.
    c. Your provider could fax the form to Paid Leave at 651-797-1575.
    d. If you don't have a way to upload the form online, reach out to the Paid Leave Contact Center by calling 651-556-7777 or 844-556-0444 (toll-free), or by emailing PaidLeave@state.mn.us.

1. Family Member Requiring Care

Instructions: Complete this section with the information of the family member you are taking leave to care for.

1 What is the name of the family member requiring care?

Write the family member's name as it appears on official documents like a state ID, driver's license, or W-2 form.

First | Middle (optional) | Last

2 Last 4 digits of the family member's Social Security Number (SSN) or their Individual Taxpayer Identification Number (ITIN)

SSN or ITIN

3 Date of birth of the family member requiring care

Month / Day / Year

4 Phone number of the family member requiring care

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

5 Residential address of the family member requiring care

Note: This is optional. If you mail the form, we will use this information to match it to your application.

Address line 1 | Address line 2 (optional)

City | State | Zip code

2. Applicant Information

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

1 Applicant name (caregiver 1)

Write the caregiver's name as it appears on official documents like a state ID, driver's license, or W-2 form.

First | Middle (optional) | Last

Last 4 digits of caregiver's Social Security Number (SSN) or caregiver's Individual Taxpayer Identification Number (ITIN)

SSN or ITIN

Caregiver's date of birth

Month / Day / Year

Caregiver's phone number

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Caregiver's residential address

Note: This is optional. If you mail the form, we will use this information to match it to your application.

Address line 1 | Address line 2 (optional)

City | State | Zip code

Continued on the next page ...

2. Applicant Information (cont.)

1 Caregiver 1 continued

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

By signing, I authorize the healthcare provider who completes this form to confirm with Minnesota Paid Leave that the information is correct.

I certify that my family member has authorized me to share the information in this form with Minnesota Paid Leave.

Signature: _____ **Date:** ____ / ____ / ____

Month / Day / Year

Are multiple caregivers applying to take caring leave for this family member?

- If you're the only person applying for caring leave for this family member, you can skip pages 5-8. Your family member's health care provider will need to complete pages 9-13.
- If other caregivers will also be applying for caring leave for this family member, they will need to include their information on pages 5-8. Then, the family member's health care provider will need to complete pages 9-13.

2. Applicant Information (cont.)

Instructions: Complete this section with information about additional caregivers who are also applying for leave to help with care. If there aren't any other caregivers, you can share this form with your family member's healthcare provider to complete pages 9-13.

2 Applicant name (caregiver 2)

Write the caregiver's name as it appears on official documents like a state ID, driver's license, or W-2 form.

First | Middle (optional) | Last

Last 4 digits of caregiver's Social Security Number (SSN) or caregiver's Individual Taxpayer Identification Number (ITIN)

SSN or ITIN

Caregiver's date of birth

Month / Day / Year

Caregiver's phone number

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Caregiver's residential address

Note: This is optional. If you mail the form, we will use this information to match it to your application.

Address line 1 | Address line 2 (optional)

City | State | Zip code

Continued on the next page ...

2. Applicant Information (cont.)

2 Caregiver 2 continued

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

By signing, I authorize the healthcare provider who completes this form to confirm with Minnesota Paid Leave that the information is correct.

I certify that my family member has authorized me to share the information in this form with Minnesota Paid Leave.

Signature: _____ **Date:** ____ / ____ / ____

Month Day Year

2. Applicant Information (cont.)

Instructions: Complete this section with information about additional caregivers who are also applying for leave to help with care. If there aren't any other caregivers, you can share this form with your family member's healthcare provider to complete pages 9-13.

3 Applicant name (caregiver 3)

Write the caregiver's name as it appears on official documents like a state ID, driver's license, or W-2 form.

First | Middle (optional) | Last

Last 4 digits of caregiver's Social Security Number (SSN) or caregiver's Individual Taxpayer Identification Number (ITIN)

SSN or ITIN

Caregiver's date of birth

Month / Day / Year

Caregiver's phone number

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Caregiver's residential address

Note: This is optional. If you mail the form, we will use this information to match it to your application.

Address line 1 | Address line 2 (optional)

City | State | Zip code

Continued on the next page ...

2. Applicant Information (cont.)

3 Caregiver 3 continued

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

By signing, I authorize the healthcare provider who completes this form to confirm with Minnesota Paid Leave that the information is correct.

I certify that my family member has authorized me to share the information in this form with Minnesota Paid Leave.

Signature: _____ **Date:** ____ / ____ / ____

Month Day Year

4. Health condition information

This page should be filled out 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. **Note:** 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. The expected delivery date is _____ (mm/dd/yyyy).
- ☐ Has incapacitated or will incapacitate the patient for more than 7 calendar days in a row AND requires one of the following:

  Select one

  - ◯ Two or more medical visits within 30 days.

  OR

  - ◯ 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

  OR

  - ◯ A condition that would lead to a period of incapacity without treatment.
- ☐ None of the above. **Note:** If selected, the patient does not qualify for Paid Leave.

2 State the approximate date the condition started or will start.

_____ / _____ / _____

Month **Day** **Year**

Continued on the next page ...

Healthcare provider initials _____

4. Health condition information (cont.)

This page should be filled out by a healthcare provider.

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)

Healthcare provider initials _____

5. Leave information

This page should be filled out by a healthcare provider.

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.

1 ☐ **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)

2 ☐ **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 able to work _____ (◯ hours / ◯ days) per week.

3 ☐ **Intermittent:** 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.

_____

_____

Continued on the next page ...

Healthcare provider initials _____

5. Leave information (cont.)

This page should be filled out 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. **Note:** Do not use terms like unknown or TBD.

4 Does the patient require care by the applicant(s) requesting leave?

- ◯ Yes
- ◯ No

5 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: _____

6 Please list the caregiver(s).

Caregiver 1:

First _____ Middle (optional) _____ Last _____

Caregiver 2:

First _____ Middle (optional) _____ Last _____

Caregiver 3:

First _____ Middle (optional) _____ Last _____

Healthcare provider initials _____

6. Healthcare provider certification

This page should be filled out by a healthcare provider.

Instructions: Provide the relevant licensing and contact information about your practice. Sign and date to certify this leave application. After signing, return the form to the patient or their family member.

1 Provider's name

First | Middle (optional) | Last

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

Note: The form will not be accepted unless a license number is provided.

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.

Signature: _____ **Date:** ___ / ___ / ___

Month | Day | Year

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

Any healthcare provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition 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 his or her practice as defined under such law.

Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts.

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.

651-556-7777 or 844-556-0444

Attention: If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရြက္စာတမ္းအားအခမဲ့ဘာသာျပန္ေပးျခင္း အကူအညီလုိအပ္ပါက၊ အထက္ပါဖုန္းနံပါတ္ကုိေခၚဆုိပါ။

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의전화번호로연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ ງໂທຣໄປທີ່ ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

ADA Advisory

For accessible formats of this publication and additional equal access to services, write to DEED.ODEO@state.mn.us, call 651-259-7094, or use your preferred relay service. (ADA1 [9-15])

Medical leave certification form

Note about leave for your pregnancy

If you will be taking continuous Medical Leave due to pregnancy or recovery from birth AND Bonding Leave to bond with your newborn right after recovering from the birth, use the Pregnancy-related Medical Leave Certification form instead.

This form has four sections:

1. **Applicant information**
2. **Health condition information**
3. **Leave information**
4. **Healthcare provider certification**

How to complete this form:

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

1. Complete the applicant information section.
2. Give this form to the healthcare provider who is treating you. Page 7 lists the kind 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. There are several ways to get your form to us.
    a. If you have completed this form digitally, you can upload the completed file online at paidleave.mn.gov.
    b. If you printed the form, you can upload photos or a scan of the completed form.
    c. Your provider could fax the form to Paid Leave at 651-797-1575.
    d. If you don't have a way to upload the form online, reach out to the Paid Leave Contact Center by calling 651-556-7777 or 844-556-0444 (toll-free), or by emailing PaidLeave@state.mn.us.

1. Applicant Information

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

1 Applicant name

Write your name as it appears on official documents like a state ID, driver's license, or W-2 form.

First _____ Middle (optional) _____ Last _____

2 Last 4 digits of your Social Security Number (SSN) or your Individual Taxpayer Identification Number (ITIN)

SSN or ITIN _____

3 Date of birth

Month ____ / Day ____ / Year ____

4 Phone number

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

5 Residential address

Note: This is optional. If you mail the form, we will use this information to match it to your application.

Address line 1 _____ Address line 2 (optional) _____

City _____ State _____ Zip code _____

6

To take Medical Leave, your serious health condition must prevent you for 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: _____

7

By signing, I authorize the healthcare provider who completes this form to confirm with Minnesota Paid Leave that the information is correct.

Signature: _____ **Date:** ____ / ____ / ____

Month Day Year

2. Health condition information

This page should be filled out by a healthcare provider.

Instructions: For the patient to qualify for Paid Leave, they must have a serious health condition. This is defined as an illness, injury, impairment, or condition (including mental health conditions, pregnancy, or substance use disorders) that affects a person's physical or mental health. Answer all questions fully and completely.

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. The expected delivery date is _____ (mm/dd/yyyy).
- ☐ Has incapacitated or will incapacitate the patient for more than 7 calendar days in a row AND requires one of the following:

  Select one

  - ○ Two or more medical visits within 30 days.

  OR

  - ○ 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

  OR

  - ○ A condition that would lead to a period of incapacity without treatment.
- ☐ None of the above. **Note:** If selected, the patient does not qualify for Paid Leave.

2 State the approximate date the condition started or will start.

_____ / _____ / _____

Month **Day** **Year**

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

_____

Healthcare provider initials _____

2. Health condition information (cont.)

This page should be filled out by a healthcare provider.

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)

5 Do you agree that the patient cannot or will not be able to do the type(s) of job duties they indicated in section 1 of this medical certification form?

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

Healthcare provider initials _____

3. Leave information

This page should be filled out by a healthcare provider.

Instructions: The applicant's healthcare provider should complete this section. The following questions are about the frequency or duration of a condition. Check all that apply to the patient's 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. **Note:** 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?

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?

Provide your best estimate of the time that the patient should take off per week during the following dates:

Start date: _____ (mm/dd/yyyy) **End date:** _____ (mm/dd/yyyy)

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

3 ☐ **Intermittent:** 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?

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.

_____

_____

Healthcare provider initials _____

4. Healthcare provider certification

This page should be filled out by a healthcare provider.

Instructions: Provide the relevant licensing and contact information about your practice. Sign and date to certify this leave application. After signing, return the form to the patient.

1 Provider's name

First | Middle (optional) | Last

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

Note: The form will not be accepted unless a license number is provided.

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.

Signature: _____ **Date:** ____ / ____ / ____

Month | Day | Year

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. Visit paidleave.mn.gov to learn more about how Paid leave defines a serious health condition.

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 health care 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 to provide treatment.

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

Any healthcare provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition 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 his or her practice as defined under such law.

Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts.

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.

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