



*Health Care Provider
LaborFirst
User Guide*

LaborFirst Health Provider User Guide

Table of Contents

LaborFirst Health Provider User Guide.....	1
Table of Contents	1
User Guide: Health Care Provider Certification Process	1
Receive Form ID Email	2
Enter Form ID	3
Review of Important Information	3
Enter Health Care Provider Information.....	4
Review Patient Information.....	5
Complete Health Care Provider Certification.....	6
Enter Amount of Leave Needed.....	6
Summary	8
Confirmation.....	8

User Guide: Health Care Provider Certification Process

Claims for **Medical Leave** or **Family Caregiver Leave** require certification from a healthcare provider. The process involves:

1. Claimant submits a Paid Family Medical Leave claim through **LaborFirst**.
2. Claimant provides the healthcare provider with the **Form ID** for medical certification.
3. Healthcare providers complete the certification in **LaborFirst**.

Receive Form ID Email

After the claim is filed, the claimant receives an email containing the **Form ID**. The email includes:

- The **Form ID**.
- Instructions for completing the Certification of Serious Health Condition.
- Helpful links and resources.

Healthcare providers must use this **Form ID** to access the certification form.

PFML Health Care Provider Certification Form ID Claim ID CLM-00001308



LaborFirst <laborfirstnotifications@delaware.gov>

To: ○ Samuel Smokrovich

① This sender laborfirstnotifications@delaware.gov is from outside your organization.

[Reply](#) [Reply All](#) [Forward](#) [Print](#) [...](#)

Tue 10/28/2025 3:45 PM

October 27, 2025

Hello Paul Bishop,

You applied on October 27, 2025 for leave for your family member's serious health condition.

To complete your claim, please give your Health Care Provider a copy of this email. They will need the Form ID below to fill out the Certification of Serious Health Condition.

Form ID: d3ff7edd-9e1e-4e98-89d4-445990a177d3

Important information for your Health Care Provider:

- The Certification of Serious Health Condition form must be completed electronically. Use this [link](#). You can also find this form on the Delaware LaborFirst website [Delaware Paid Leave - Delaware Department of Labor](#)
- Enter the unique Form Id listed above.
- Fill out all required patient information.

Please contact the Division of Paid Leave at PFML@delaware.gov if you have any questions.

Regards,

Chris Counihan
Director, Division of Paid Leave
Delaware Department of Labor
24/7/365 Call Center: (302) 761-8375
Email: PFML@Delaware.gov



Email

Enter Form ID

Navigate to the public link provided. **Copy the form ID** from the email and enter the ID into the designated field. Enter the **Form ID** in the designated field. Select **Next** to proceed.

<p>Enter Form ID</p> <p>Please enter the Form ID that you received for this Certification of Serious Health Condition.</p> <p>*Form ID <input type="text"/></p>	<p>Steps</p> <p><input checked="" type="radio"/> Enter Form ID</p>
<p style="text-align: right;">Next</p>	

Form ID Screen

Review of Important Information

The **Important Information** screen provides details needed for certification. Please read the important information.

Once reviewed, select **Next**.

<p>Important Information</p> <p>You as the provider will need to provide some information about yourself before filling out the Certification of Serious Health Condition.</p> <p>Once you have provided your information you will be presented with the Certification of Serious Health Condition where you will need to provide the following information about your patient:</p> <ul style="list-style-type: none">• Date(s) of hospitalization, procedure(s), and treatment(s)• Date(s) of planned hospitalization(s), procedure(s), and treatment(s)• Frequency and/or duration of treatment and expected periods of recovery• Medical necessity for patient or their family member's absence from work, including reduced hours in the workday and intermittent days off from work <p>Be sure to review the Claim Summary prior to completing the Certification.</p>	<p>Steps</p> <p><input checked="" type="radio"/> Important Information</p> <p><input type="radio"/> Health Care Provider Information</p>
<p style="text-align: right;">Next</p>	

Important Information Screen

Enter Health Care Provider Information

Provide Personal Information:

Enter the **First Name**, **Last Name**, **Contact Details**, **Type of Practice/Medical Specialty**, **NPI Number** and provide **Business Address**, **City**, **State**, and **Zip code** then select **Next**.

(Note: All Red Asterisk fields are mandatory, please complete those fields)

Health Care Provider Information

Personal Information

* First Name	Middle Name
<input type="text"/>	<input type="text"/>
* Last Name	Suffix
<input type="text"/>	<input type="text"/>
* Phone Number	Email
<input type="text"/>	<input type="text"/>
* Type of practice / Medical Specialty:	* NPI Number <small>?</small>
<input type="text"/>	<input type="text"/>

Business Address

* Address Line 1 <small>?</small>	* City
<input type="text"/>	<input type="text"/>
* State	* Zip/Postal Code
<input type="text"/>	<input type="text"/>

Steps

- Important Information
- Health Care Provider Information

Previous Next

Health Care Provider Information Screen

Review Patient Information

The patient's information will prepopulate on employee and family member, when applicable. As displays the **Claim Summary** in read-only format.

Select the hyperlink to view the claimant's claim summary. After reviewing the summary.

Select the **Certification Check Box** confirming you reviewed the claim summary and select **Next** to proceed.

Patient Information

This claim being filed is for: **Medical Leave**
Below is information on the claimant/patient that is requesting medical or family caregiving leave

Claimant Information

First Name <input type="text" value="Larry"/>	Middle Name <input type="text"/>	Last Name <input type="text" value="Lennon"/>
Date of Birth <input type="text" value="12/01/1992"/>	Employer Name <input type="text" value="Training Employer"/>	Job Title <input type="text" value="Training Lead"/>
Essential Job Function <input type="text" value="Training newly hired employees"/>		

Select the hyperlink to view the claimant's claim summary in order to proceed. (This will open in a new tab so you can view it as you complete the Certification of Serious Health Condition) [Claim Summary](#)

I have opened the claim summary

[Previous](#) [Next](#)

Steps

- Important Information
- Health Care Provider Information
- Patient Information**
- Health Care Provider Certification
- Amount of Leave Needed
- Summary
- Confirmation

Patient Information Screen

Complete Health Care Provider Certification

The first thing you need to do is choose “Yes” or “No” for the question: Is this serious health condition related to a workers’ compensation claim?

Then enter in the details about the claimant’s health condition: Date started and the Estimated duration. Select applicable health conditions, if **None of the Above** is selected, the claim is ineligible. Select **Next**.

Health Care Provider Certification

This claim being filed is for: **Medical Leave**
 Select the hyperlink to view the claimant's **Claim Summary** for your review

* Is this serious health condition related to a worker's compensation claim?
 Yes No

* Please indicate the date the serious health condition started * Please provide best estimate of how long condition will last

* Please select all applicable serious health conditions from the list below:

- Inpatient Care
- Incapacity plus Treatment
- Complications with Pregnancy
- Chronic Conditions
- Permanent or Long-Term Conditions
- Conditions Requiring Multiple Treatments
- None of the Above

Previous Next

Steps

- Important Information
- Health Care Provider Information
- Patient Information
- Health Care Provider Certification**
- Amount of Leave Needed
- Summary
- Confirmation

Health Care Provider Certification Screen

Enter Amount of Leave Needed

Indicate if leave is medically necessary (Yes/No). If Yes, click **Add New** to enter leave schedule details.

Amount of Leave Needed

This claim being filed for: **Medical Leave**
 Select the hyperlink to view the claimant's **Claim Summary** for your review
 Based on the medical condition(s) previously selected, complete all that apply. Please provide your **best estimate** of the frequency and duration of a condition or treatment as well as the leave schedule needed. Be as specific as you can.

* Due to the condition(s), is it medically necessary for claimant to take leave?
 Yes No

+ [Add New](#)

 [Leave Schedules](#)

Which Leave Schedule is Recommended Start Date End Date

Previous Next

Steps

- Important Information
- Health Care Provider Information
- Patient Information
- Health Care Provider Certification
- Amount of Leave Needed**
- Summary
- Confirmation

Amount of Leave Needed Screen

HCP LaborFirst User Guide

Choose leave type: Continuous, Reduced Hours Per Day, Reduced Days Per Week, or Intermittent. Enter start and end dates, once done. Select **Save**, to save the dates.

1. **Continuous:** A leave schedule in which leave is taken all at once in a single, uninterrupted block of time.
2. **Reduced Hours Per Day:** A leave schedule that allows a claimant to work fewer hours per day. Enter the percentage of a full workday the claimant can still work. Example: If they can work half the day, enter 50%.
3. **Reduced Days Per Week:** A leave schedule that allows a claimant to work fewer days per week. Enter the number of days the claimant can still work.
4. **Intermittent:** A leave schedule that allows leave to be taken in separate blocks of time on a periodic basis, rather than a continuous period of time. The blocks of time can vary in length. Example: The claimant may miss a few days of work each month when a chronic condition like migraines or asthma flares up.

*Which leave schedule is recommended for this claimant

Continuous Reduced Hours Per Day Reduced Days Per Week Intermittent

Example: Your regular work week is Monday through Friday, and you plan to take leave from January 12 ending January 26. In Delaware LaborFirst, a week is defined as Sunday through Saturday. To enter your leave correctly, select "Continuous" for the period of January 11 through January 24, since this covers two full weeks of leave. Then, create a separate leave period for the week of January 25 using the "Reduced Days Per Week" option, and select one day of leave for January 26.

January 2026

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3

Leave Schedule Details Screen

Once the leave has been saved, it will display under the Leave Schedule panel. Select **Next** to proceed.

Amount of Leave Needed

This claim being filed for: **Medical Leave**
 Select the hyperlink to view the claimant's [Claim Summary](#) for your review
 Based on the medical condition(s) previously selected, complete all that apply. Please provide your **best estimate** of the frequency and duration of a condition or treatment as well as the leave schedule needed. Be as specific as you can.

* Due to the condition(s), is it medically necessary for claimant to take leave?
 Yes No

Steps

- Important Information
- Health Care Provider Information
- Patient Information
- Health Care Provider Certification
- Amount of Leave Needed**
- Summary
- Confirmation

[Previous](#)
[Next](#)

Selected Leave Schedule Details Screen

Summary

Review and verify all entered information. **Select the Disclosure Check Box. Sign, date, and select Next.**

Summary

- > Health Care Provider Information
- > Health Care Provider Certification
- > Amount of Leave Needed

Please check this box to certify, under pains and penalties of perjury, that all information provided in this filing is complete and true to the best of your knowledge and belief.

* Signature

* Date

Previous
Next

Steps

- Important Information
- Health Care Provider Information
- Patient Information
- Health Care Provider Certification
- Amount of Leave Needed
- Summary**
- Confirmation

Summary Screen

Confirmation

A confirmation screen appears with a Confirmation Number. Retain this number for your records. Select **Finish** to close the process.

Confirmation

Confirmation Number: CON-38489

Thank you for submitting the Certification of Serious Health Condition to the Delaware Department of Labor, Division of Paid Leave on behalf of the claimant.

Please retain a copy of this confirmation for your records.

Finish

Steps

- Important Information
- Health Care Provider Information
- Patient Information
- Health Care Provider Certification
- Amount of Leave Needed
- Summary
- Confirmation

Confirmation Number Screen