CERTIFICATION OF HEALTH CARE PROVIDER
FAMILY AND MEDICAL LEAVE ACT/CALIFORNIA FAMILY RIGHTS ACT

Section I: <u>For Completion by Employer- Instructions to Employer</u>

The Family and Medical Leave Act ("FMLA") and the California Family Rights Act ("CFRA") provide that an employer may require an employee requesting FMLA and/or CFRA leave because of a need for leave due to a serious health condition to submit a health care provider certification issued by the employee's health care provider or the health care provider of the employee's covered family member. Please complete **Section I** before giving this form to your employee.

Employer's name:_____

Employer contact telephone number:_____

Employer contact:_____

Employee's job title:_____

Employee's regular work schedule:_____

Employee's essential job functions: ☐ attached is the job description and/or list of essential job functions.

Section II: <u>For Completion by Employee - Instructions to Employee</u>

Please complete Section II before giving this form to your health care provider. The FMLA and/or CFRA permit an employer to require that you submit a timely, complete, and sufficient health care provider certification to support a request for FMLA and/or CFRA leave due to your own serious health condition or to care for a spouse, registered domestic partner, child, or parent with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA and/or CFRA protections. Failure to provide a complete and sufficient health care provider certification may result in a denial or delay of your FMLA and/or CFRA request, or non-designation of your leave as FMLA and/or CFRA leave. You have 15 calendar days to return this form.

Employee name:_____
[First] [Middle] [Last]

Employee must complete Questions 1 through 3 below if time off is needed to care for a spouse, registered domestic partner, child, or parent:

1. Name of family member for whom you will provide care:

_____

[First] [Middle] [Last]

2. Relationship of the family member to you:_____

If the family member is your son or daughter, date of birth:_____

3. State the care you will provide to your family member and an estimate of the time period during which care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:_____

_____

_____

_____

_____

Section III: <u>For Completion by Health Care Provider - Instructions to Health Care Provider</u>

The employee identified in Section I has requested leave under the FMLA and/or CFRA for his or her serious health condition and/or to care for a covered family member. Please fully answer all of the questions below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA and/or CFRA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, or genetic services. Finally, please be sure to sign the form on the last page.

1. Patient's name (if different from employee):_____

2. Approximate date condition or need for treatment commenced:_____
   [Note: The Health Care Provider is not to disclose the underlying diagnosis without the consent of the patient]

3. Probable duration of medical condition or need for treatment:_____

4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No
   If so, provide dates of admission: _____

5. Date(s) you treated the patient for condition:_____

6. Will the patient need to have treatment visits at least twice per year due to the condition?
   ☐ Yes ☐ No

7. Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

8. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

If so, please state the expected duration of treatment:_____

9. The attached sheet describes what is meant by a "serious health condition" and "incapacity" under the law. Does the patient's condition qualify under any of the categories described?
☐ Yes ☐ No

If so, please select the appropriate category: (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐

Answer Questions 10 - 13 if the certification is for the serious health condition of the employee.

10. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his and/or her job functions.

a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or chronic condition), is the employee unable to perform work of any kind? ☐ Yes ☐No

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's position? ☐ Yes ☐ No
If so, identify the job functions the employee is unable to perform:_____
_____
_____
_____

11. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No
If so, estimate the beginning and ending dates for the period of incapacity:_____

12. Will the employee need intermittent leave to attend follow-up treatment appointments or need to work part time or on a reduced schedule because of the employee's medical condition?
☐ Yes ☐ No
a. If so, are the treatments or the reduced number of hours of work medically necessary?
☐ Yes ☐ No

b. Estimate the number of treatments if any, including the treatment schedule and dates of any scheduled appointments and the time required for each appointment, including any recovery period:_____

c. Estimate the part-time or reduced work schedule the employee needs, if any:
_____hour(s) per day _____days per week from _____through _____

13. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

a. Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

b. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

The following questions should only be answered if this certification is for the employee to care for a family member.

14. If leave is required to care for a spouse, registered domestic partner, child, or parent of the employee with a serious health condition, does (or will) the family member require assistance for basic medical, hygiene, nutritional needs, safety, or for transportation? ☐ Yes ☐ No

a. After reviewing the information provided by the employee in Section II (Item 3) above, does the patient's condition warrant the participation of the employee (This participation may include psychological comfort and/or arranging for third party care for the family member)? ☐ Yes ☐ No

b. Estimate the period of time care is needed or during which the employee's presence would be beneficial: _____
_____

15. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No
If so, estimate the beginning and ending dates for the period of incapacity:_____

16. Will the patient require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

a. Is it medically necessary for the employee to be off work for these follow-up treatments and recovery periods? ☐ Yes ☐ No

b. Estimate the treatment schedule and dates of any scheduled appointments and the time required for each appointment, including any recovery period:_____

_____

17. Is it medically necessary for the employee to be off work on an intermittent or reduced schedule basis to provide care for the patient, including any time for recovery? ☐ Yes ☐ No

Estimate the hours the patient needs care on an intermittent or reduced schedule basis, if any:

_____Hour(s) per day _____ day(s) per week from _____ through _____

18. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

a. Is it medically necessary for the employee to be absent from work to provide care during the flare-ups? ☐ Yes ☐ No

b. Based upon the patient's medical history and your knowledge of the medical condition, the frequency of flare-ups and the duration of related incapacity that the patient have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ time(s) per _____ week(s) or _____ month(s)

Duration: _____ hour(s) per day _____ day(s) per episode

_____ _____

Type of Practice / Specialty Employee's Signature

_____ _____

Address Date

_____

City State and Zip Code

_____

Signature of Health Care Provider

_____

Date

SERIOUS HEALTH CONDITION AND INCAPACITY

The term “incapacity” means inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore or recovery there from.

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 facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

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

   (a) Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, 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

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

3. Pregnancy

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

   Note: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.

4. Chronic Conditions Requiring Treatment

   Any period of incapacity or treatment for such incapacity due to a chronic condition. A chronic condition is one which:

   (a) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

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

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

5. Permanent/Long-term Conditions Requiring Supervision

   A period of incapacity 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.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery there from) 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:

(a) for restorative surgery after an accident or other injury, or

(b) 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.), severe arthritis (physical therapy), kidney disease (dialysis).

Attachment:

Essential Functions of Position