Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

Part A: For completion by the person responsible for administering the leave program.

Roxanne Robinson, (805) 493-3177 Company Name and Contact

Attach a copy of the employee's job description and the essential job functions of the employee's position to this form.

Part B: For completion by the Employee

Instructions for the employee: The law permits us to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA/CFRA leave to care for yourself or a covered family member with a serious health condition. Failure to provide a complete and sufficient medical certification may result in a denial of your request. You have **15 calendar days** to return this form to the company.

_____ _____

Employee Name Daytime Contact Number

If the request is for care for a family member:

_____

Name of the family member/patient for whom you will provide care

Relationship of family member to you: ☐child/child of domestic partner ☐spouse ☐parent ☐domestic partner

If the family member is your son or daughter: Date of birth_____

I certify that the information I have provided is true and correct.

_____ _____

Employee Signature Date

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Part C: For completion by the Patient's Health Care Provider

Instructions for the health care provider: The employee listed above has requested leave to care for himself/herself or for your patient who is a family member listed above. Please answer fully and completely all applicable parts 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/CFRA coverage. Limit your responses solely to the condition for which the patient needs leave. Please be sure to sign the form. **PLEASE DO NOT DISCLOSE THE UNDERLYING DIAGNOSIS, INCLUDING ANY GENETIC INFORMATION*, WITHOUT THE CONSENT OF THE PATIENT.**

1. Date medical condition or need for treatment commenced: _____

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

3. *Attachment A: Definitions* describes what is meant by a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient's condition qualify under any of the categories described?

   ☐ Yes ☐ No

4. If the certification is for the serious health condition of the employee, please answer the following:

   a. Is the employee able to perform work of any kind?

      ☐ Yes ☐ No (If "no" skip next question)

   b. Is the employee unable to perform one or more of his/her essential functions of the employee's position? (Answer after reviewing the attached job description provided by the employee that includes the essential functions of the employee's position.)

      ☐ Yes ☐ No

      If yes, to 4b, please identify the job functions the employee is unable to perform.

      _____

      _____

5. If the certification is for the care of the employee's family member, please answer the following:

   a. The patient does, or will, require assistance for basic medical, hygiene, nutritional needs, safety or transportation needs or the provision of physical or psychological care.

      ☐ Yes ☐ No

   b. After review of the signed *Employee's Statement Regarding Seriously Ill Family Member* (Attachment B), does the 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

6. Estimate the period of time care will be needed or during which the employee's presence would be beneficial:

   _____

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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7. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule:
   a. Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member?

      ☐ Yes ☐ No

   b. If the answer to 7a is yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider: _____

_____ _____
Signature of Health Care Provider Date

_____ _____
Signature of Employee Date

Physician or Practitioner Information:

_____
Physician's or Practitioner's Name

_____
Address

_____ ____ _____-_____
City State Zip

(____) ____-_____
Telephone

_____

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Attachment A: Definitions

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 incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

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

      - Treatment two or more times by a health care provider (for FMLA only, the two treatments must occur within 30 days ***), 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
      - 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.
      - For FMLA only, the employee's first treatment must occur within 7 days of first day of incapacity. ***

3. Pregnancy

   A 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

   A chronic condition which:

   a. Requires periodic visits (for FMLA ONLY periodic means at least two times per 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 that 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 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 treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).

*** California law does not include these time limitations. If a leave is FMLA/CFRA, follow the California law without these time limitations.

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Attachment B: Employee's Statement Regarding Seriously Ill Family Member

To be completed and signed by the employee needing family leave to care for a seriously ill family member. Employee should provide this section to the health care provider under separate cover. **This information is not to be provided to the employer.**

When family care leave is needed to care for a seriously ill family member, the employee must state the care he/she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the information I have provided is true and correct.

_____ _____

Signature of Employee Date

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