Certification of Health Care Provider for Family Member's Serious Health Condition

Family and Medical Leave Act ("FMLA") & California Family Rights Act ("CFRA")

PURPOSE of FORM: The below-named employee has requested a leave of absence to care for a family member with a health condition, which may qualify as a protected leave under the FMLA and/or CFRA. This medical certification form will provide the University with information needed to determine if the employee's requested leave is for a qualifying reason under the FMLA and/or CFRA. Section III must be fully completed by the health care provider.

SECTION I – To be completed by EMPLOYER

Employee's name: _____

Name and contact of University representative:

_____

_____

SECTION II – To be completed by EMPLOYEE

INSTRUCTIONS to EMPLOYEE: Please complete and sign Section II before giving this form to your family member or his/her health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA and/or CFRA leave due to your family member's serious health condition. Providing this completed form is required to obtain (or retain) the benefit of FMLA and/or CFRA protections for your leave. Failure to provide a complete and sufficient medical certification to your employer may result in a delay or denial of your leave request, and could also lead to discipline or termination.

You must return this completed form within 15 calendar days of your employer's request for this information, or no later than _____20____. You may return the form in person, by mail, or by fax. The fax number is _____. You should include a fax cover sheet marked "CONFIDENTIAL" and address your fax to "ATTENTION: _____."

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

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

Describe care you will provide to your family member and estimate the duration of leave needed to provide care:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Employee Signature **Date**

SECTION III – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA and/or CFRA to care for your patient. 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 to the condition for which the patient needs the employee's care. Page 3 provides space for additional information, should you need it. Please be sure to sign and date the form on Page 3.

Provider's name and business address: _____
_____
Type of practice: _____
Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____
Probable duration of condition: _____

2. Page 4 describes what is meant by a "serious health condition" under both the FMLA and CFRA. Does the patient's condition qualify under any of the categories described? _____No ___Yes.
If yes, which type of serious health condition listed on Page 4 applies: ____1 ____2 ____3 ____4 ____5 ____6

For FMLA purposes only:
If the patient's serious health condition is **type 2** (as defined on Page 4), did the patient visit a health care provider within 7 days of his/her first day of incapacity? ____ No ____ Yes.
If the patient's serious health condition required at least two visits to a health care provider, was the second visit to a health care provider within 30 days of the patient's first day of incapacity? _____ No _____ Yes.
If the patient's serious health condition is **type 4** ("chronic condition," as defined on Page 4), will the condition require two or more visits to a health care provider per year? _____No _____ Yes.

PART B: AMOUNT OF CARE NEEDED

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

3. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.
Estimate the beginning and ending dates for the period of incapacity: _____
_____
During this time, will the patient need care? __ No __ Yes.
Explain the care needed by the patient and why such care is medically necessary: _____
_____
_____
_____
_____

4. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.
Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____
_____
_____

Explain the care needed by the patient, and why such care is medically necessary: _____
_____
_____
_____
_____

5. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
____ No ____ Yes.
Estimate the hours the patient needs care on an intermittent basis, if any: _____ hour(s) per day; _____ days per week from _____ through _____.
Explain the care needed by the patient, and why such care is medically necessary: _____
_____
_____
_____
_____

6. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.
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
Does the patient need care during these flare-ups? ____ No ____ Yes.
Explain the care needed by the patient, and why such care is medically necessary: _____
_____
_____
_____
_____

ADDITIONAL INFORMATION:
_____
_____
_____
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_____
_____

_____ _____
Signature of Health Care Provider **Date**

Serious Health Conditions

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Inpatient 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. **Incapacity of More Than 3 Consecutive Days <u>Plus</u> Continuing Treatment by a Health Care Provider**
   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:

   (a) <u>Treatment</u> <u>two or more times</u> by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provided, 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) <u>Treatment</u> by a health care provider on <u>at least one occasion</u> which results in <u>a regimen of continuing treatment</u> under the supervision of the health care provider (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). Note: This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

3. **Pregnancy**
   A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.
   (Covered under the FMLA only)

4. **Chronic Conditions Requiring Treatment**
   A chronic condition which:

   a. 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;
   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 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.) severe arthritis (physical therapy), kidney disease (dialysis).