Certification of Health Care Provider for Employee'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 for his/her health condition that 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 II must be fully completed by the health care provider.

INSTRUCTIONS to EMPLOYEE: 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 own 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.

You must return this completed form within 15 calendar days of our 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: _____."

SECTION I – To be completed by EMPLOYER

Employee's name: _____

Name and contact information of University representative:

_____

Employee's job title: _____

Regular work schedule: _____

Check if job description is attached: _____

SECTION II – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient (our employee) has requested leave under the FMLA and/or CFRA. Please answer, fully and completely, all applicable parts. 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 employee. 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 employee is seeking leave. Be sure to sign and date the form on page 2.

NOTE: DO NOT DISCLOSE THE EMPLOYEE'S UNDERLYING DIAGNOSIS WITHOUT HIS/HER CONSENT.

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 3 describes what is meant by a "serious health condition" under both the FMLA and CFRA. Does the employee's condition qualify as one of the types of serious health conditions described? ____No ___Yes.

If yes, which type of serious health condition listed on page 3 applies: ____1 ____2 ____3 ____4 ____5 ____6

For FMLA purposes only:

If the employee's serious health condition is **type 2** (as defined on page 3), did the employee visit a health care provider within 7 days of his/her first day of incapacity? ____ No ____ Yes

If the employee'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 employee's first day of incapacity? ____ No ____ Yes.
If the employee's serious health condition is **type 4** ("chronic condition" as defined on page 3), will the condition require two or more visits to a health care provider per year? _____No _____ Yes

3. Use the information provided by in Section I to answer these questions. If no job description has been provided, please answer these questions based upon the employee's own description of his/her job functions.

Is the employee <u>able</u> to perform work of any kind? ____ No ____ Yes.
If yes, is the employee <u>unable</u> to perform one or more of the essential functions of his/her position due to the condition? ____ No ____ Yes. If so, describe the essential function(s) that s/he cannot perform:
_____
_____
_____
_____

PART B: AMOUNT OF LEAVE NEEDED

4. 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? ___No ____Yes. If yes, estimate the beginning <u>and</u> ending dates for the period of incapacity: _____

5. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.
If yes, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.
Estimate the treatment schedule, if any, including the frequency of any scheduled appointments and the duration required for each appointment, including any recovery period: _____
_____
_____

Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from _____ through _____.

6. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No _____Yes.
Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes.
If yes, explain: _____
_____

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

ADDITIONAL INFORMATION:
_____
_____
_____
_____
_____
_____

_____ _____
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).