CERTIFICATION OF HEALTH CARE PROVIDER FORM

INSTRUCTIONS FOR EMPLOYEE: This form is to be completed by your health care provider (if this leave is for your own serious health condition) or by your family member's health care provider (if this leave is for the serious health condition of a spouse/domestic partner, parent, child, Grandparent, Grandchild, or Sibling). Once complete, return this form **15 days** prior to the first day of leave, except in an emergency.

1. Employee's Name: _____

2. Patient's name (If other than employee): _____

3. First Day of Absence: _____
(NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT)

4. Probable duration of medical condition or need for treatment.

   Anticipated Return Date: _____

5. The attached sheet 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? If so, please check the appropriate category:

   (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐

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

YES	NO	
☐	☐	Is employee able to perform work of any kind? (If "No", skip next question.)
☐	☐	Is employee unable to perform any one or more of the essential functions of the employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

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

YES	NO	
☐	☐	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
☐	☐	After review of the employee's signed statement (See Item 10 below), 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.)

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

First Day of Absence: _____ Anticipated Return Date: _____

9. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule:

YES	NO	
☐	☐	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?
☐	☐	If the answer to 9 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.

_____

_____

_____

Physician's Name:		Office Telephone Number:	
Office Address	City	State	Zip Code

I, the undersigned health care provider, certify that the information I have provided regarding the above-referenced individual is complete and accurate to the best of my knowledge.

_____	_____	_____
Health Care Provider Signature	License No.	Date

ITEM #10 IS TO BE COMPLETED <u>BY THE EMPLOYEE</u> NEEDING FAMILY LEAVE

10. When family care leave is needed to care for a seriously ill family member, the employee shall state the care he or 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.

_____

_____

_____

_____ _____

Employee Signature Date

SERIOUS HEALTH CONDITION

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:

   (1) Treatment two or more times 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

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

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

4. Chronic Condition Requiring Treatment

   (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 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 a 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 or treatment, such as cancer, (Chemotherapy, radiation, etc.), severe arthritis, (physical therapy), kidney disease (dialysis).

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