**CERTIFICATION OF HEALTH CARE PROVIDER**

**California Family Rights Act (CFRA) and**

**Family and Medical Leave Act (FMLA)**

*[To Be Completed by Patient’s Healthcare Provider]*

**1. Employee’s name:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Patient’s name (if other than employee):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Patient’s relationship to employee (if other than employee) (i.e., child, parent, grandparent, grandchild, sibling, spouse or domestic partner):**

**4. Date medical condition or need for treatment commenced:**

***[NOTE: The health care provider is not to disclose any genetic information of employee or family member of employee and is not to disclose the underlying diagnosis without the consent of the patient]:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.** **Probable duration of medical condition or need for treatment:**

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**6.** **Attached is a description of what constitutes a “serious health condition” under both the California Family Rights Act (CFRA) and the federal Family and Medical Leave Act (FMLA).**

**Does the patient’s condition qualify as a serious health condition?**

□ Yes □ No

**7.** **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? (If “No,” skip next question)

□ Yes □ No

b. Is the employee unable to perform any one or more of the essential functions of employee’s position? (Answer after reviewing statement from employer of essential functions of the employee’s position, or, if none provided, after discussing with employee.)

□ Yes □ No

If yes to either a or b, please provide any proposed or recommended accommodations:

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**8.** **If the certification is for the care of the employee’s family member, please answer the following:**

Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

□ Yes □ No

After review of the employee’s signed “Employee’s Statement Regarding Seriously Ill Family Member,” 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

**9.** **Estimate the period of time the employee’s family member will need care during which the employee’s presence would be beneficial to participate in care for the employee’s family member:**

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**10.** **Please answer the following questions only if the employee is asking for intermittent leave or a reduced work schedule.**

*Intermittent Leave*: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee or family member?

□ Yes □ No

If yes, please indicate the estimated frequency of the employee’s need for intermittent leave due to the serious health condition, and the duration of such leaves (*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

*Reduced Schedule Leave*: Is it medically necessary for the employee to work less than the employee’s normal work schedule due to the serious health condition of the employee or family member?

□ Yes □ No

If yes, please indicate the part-time or reduced work schedule the employee needs:

Frequency: \_\_\_\_\_\_ hour(s) per day; \_\_\_\_\_\_ days per week, from \_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_.

*Time Off for Medical Appointments or Treatment:* Is it medically necessary for the employee to take time off work for doctor’s visits or medical treatment, either by the health care practitioner or another provider of health services?

□ Yes □ No

If yes, please indicate the estimated frequency of the employee’s need for leave for doctor’s visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: times per week(s) month(s)

Duration: \_\_\_\_\_\_\_\_ hours or \_\_\_\_\_\_\_ day(s) per appointment/treatment

HEALTH CARE PROVIDER:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

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Printed Name Phone Number

EMPLOYEE:

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Phone Number

**DEFINITION OF SERIOUS HEALTH CONDITION**

“Serious Health Condition” means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner of the employee that involves either inpatient care or continuing treatment including, but not limited to, treatment for substance abuse. A Serious Health Condition may involve one or more of the following:

***HOSPITAL CARE***

Inpatient care 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. A person is considered an “inpatient” when a health care facility formally admits him or her to the facility with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

***ABSENCE PLUS TREATMENT***

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.

***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.*

***CHRONIC CONDITIONS REQUIRING TREATMENT***

A chronic condition which:

1. 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;

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

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

***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.

***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).

**EMPLOYEE’S STATEMENT REGARDING SERIOUSLY**

**ILL FAMILY MEMBER**

(To be completed and signed by an employee requesting Family Leave to care for a

seriously ill family member. Please provide this information to the health care provider.)

If you are seeking leave to care for a seriously-ill family member, please provide a description of the care you will provide for your family member, 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.

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Signature of Employee Date