



CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION Family and Medical Leave Act of 1993 (FMLA) and California Family Rights Act of 1993 (CFRA)

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

**When family care leave is needed to care for a seriously-ill family member, the employee shall, under separate cover provided to the health care provider, 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.**

1. Employee's Name: \_\_\_\_\_

2. Patient's Name: \_\_\_\_\_

Patient's relationship to employee: \_\_\_\_\_

If patient is employee's child, is patient either under 18 or an adult dependent child:

Yes  No

**Please do not disclose the underlying diagnosis without the consent of your patient. Please limit responses to the condition which the employee is seeking leave for the family member.**

3. Date medical condition or need for treatment commenced: \_\_\_\_\_

4. Probable duration of medical condition or need for treatment: \_\_\_\_\_

5. Below is a description of what constitutes a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA).

--- 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, or spouse 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:

1. *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.

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*

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

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 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 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), or kidney disease (dialysis).

Does the patient's condition qualify as a serious health condition, as defined above?

Yes  No

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

Yes  No

7. Employee must provide a signed statement to the family member's physician listing the type of care he/she will be providing to his/her family member, with the information noted below. Did you receive a written and signed statement from our employee?

Yes  No

8. After review of the employee's signed statement, 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 care is needed or during which the employee's presence would be beneficial: \_\_\_\_\_

\_\_\_\_\_

10. Please answer the following question **only** if the employee needs leave on an intermittent basis or requires a reduced work schedule.

- Intermittent Leave: Please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition of the employee's family member 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

Date Intermittent Leave begins: \_\_\_\_\_

Date Intermittent Leave ends: \_\_\_\_\_

- 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 to care for the family member:

\_\_\_\_\_ 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

11. Printed name and business address of health care provider:

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

Type of practice/medical specialty: \_\_\_\_\_

Telephone number of health care provider: \_\_\_\_\_

Signature of health care provider: \_\_\_\_\_

Date: \_\_\_\_\_

12. Signature of Employee: \_\_\_\_\_

Date: \_\_\_\_\_