City of FRESNO	CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'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.

1. Employee's Name:_____

   <u>Please do not disclose the underlying diagnosis without the consent of your patient</u>. Please limit responses to the condition which the employee is seeking leave.

2. Date medical condition or need for treatment commenced: _____

3. Probable duration of medical condition or need for treatment:_____

4. 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 heath 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 employee's condition qualify as a serious health condition, as defined above? Yes☐ No☐

5. Is the employee able to perform work of any kind? Yes☐ No☐

   If no, please indicate the duration during which employee will be unable to perform work of any kind.

   Date Consecutive Leave Begins:_____

   Date Consecutive Leave Ends: _____

6. Is the employee unable to perform any one or more of the essential functions of the employee's position? (Answer after reviewing a statement from the employer of the essential functions of the employee's position, or, if none provided, after discussing with employee.) Yes☐ No☐

7. 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 their serious health condition? Yes☐ No☐

     Date Intermittent Leave Begins:_____

     Date Intermittent Leave Ends: _____

     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

     If the employee has requested leave on an intermittent basis for anticipated episodic periods of incapacity or flare ups will the condition cause or contribute to episodic flare-ups periodically preventing the employee/patient from performing his/her job functions? Yes☐ No☐

     Is it medically necessary for the employee to be absent from work during the flare-ups? Yes☐ No☐

     If yes, please explain:_____

     Please estimate the frequency of flare-ups and the duration of related incapacity that the employee may have over the next 12 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

- Reduced Schedule Leave: Is it medically necessary for the employee to work less than the employee's normal work schedule due to their serious health condition? Yes☐ No☐

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

  _____ 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?

  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

8. 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: _____
9. Signature of Employee: _____

   Date: _____