**MEDICAL CERTIFICATION FOR SERIOUS HEALTH CONDITION FOR EMPLOYEE/FAMILY MEMBER**

**(FMLA/CFRA, Except for Pregnancy Disability Leave)**

 **SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) and/or California Family Rights Act (CFRA) provides that an employer may require an employee seeking FMLA and/or CFRA protections because of a need for leave due to a serious health condition or to care for a covered family member with a serious health condition, to submit a medical certification issued by the employee’s or employee’s family member’s health care provider. Please complete Section I before giving this form to your employee. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308, and you may not require that the health care provider disclose the underlying diagnosis of the serious health condition involved. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA/CFRA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with applicable law.

Employer name and contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s job title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Regular work schedule: \_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s essential job functions (or note on attached job description): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if job description is attached: \_\_\_\_\_\_\_

 **SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your health care provider. The FMLA and/or CFRA permit an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA and/or CFRA leave due to your own serious health condition or the serious health condition of a covered family member. If requested by your employer, your response is required to obtain or retain the benefit of FMLA and/or CFRA protections. 29 U.S.C. §§ 2613, 2614(c)(3); 2 C.C.R. § 7297.4. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA/CFRA request. 20 C.F.R. § 825.313); 2 C.C.R. § 7297.4. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b); 2 C.C.R. § 7297.4

Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Middle Last

 **SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA and/or CFRA. 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 patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA and/or CFRA coverage. Limit your responses to the condition for which the employee is seeking leave.

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 or individual’s family members’ 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.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section III cont’d Medical Certification for Employee/Family Member**

To be completed by the patient’s health care provider:

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

2. Patient’s Name (if other than employee): Patient’s Relationship to Employee:

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

 If patient is employee’s child, is patient either under 18 or an adult dependent child?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Yes |  | [ ]  | No |

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

 **(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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. The attached sheet describes what is meant by a “serious health condition” as outlined by both the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient’s condition qualify as a serious health condition under any of the categories described?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Yes |  | [ ]  | No |

If yes, 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:

a. Is the employee able to perform work of any kind?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Yes |  | [ ]  | No |

b. Is the employee able to perform any one or more of the essential functions of the employee’s position? Answer after reviewing the employee’s job description that includes the essential functions of the employee’s position.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Yes |  | [ ]  | No |

1. If no, identify functions unable to perform.

If the certification is for the serious health condition of the employee, skip to Question 8.

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Yes |  | [ ]  | No |

b. After review of the employee’s signed statement (employee authorization statement on line 10) 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 |

 c. Estimate the period of time, including any specific schedule, that care will be needed or

 during which the employee’s presence would be beneficial:

 Estimate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

a. Intermittent Leave: 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 due to the serious health condition of the employee or family member?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Yes |  | [ ]  | No |

b. If the answer to question 8a is 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

1. 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:

\_\_\_\_ hour(s) per day: \_\_\_\_days per week. From \_\_\_\_\_\_\_\_\_\_\_through \_\_\_\_\_\_\_\_\_\_\_

1. 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

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

 Printed Name of Health Care Provider

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

 Signature of Health Care Provider Date

 Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIS PAGE TO BE PROVIDED TO THE HEALTH CARE PROFESSIONAL UNDER SEPARATE COVER**.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ITEM 9 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE TO CARE FOR A SERIOUSLY ILL FAMILY MEMBER.

9. When family care leave is needed to care for a seriously ill family member, the employee shall state the care the employee 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. (Use more sheets, if necessary:

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

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

 Signature of Employee Date

**Serious Health Condition**

**(Attach to Medical Certification)**

A “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 the person to the facility with the expectation that the person 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.

1. 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.

1. 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.

1. 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.).

1. 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.

1. 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).