

**Health Care Provider Certification** -- to be completed by patient's health care provider.

Employee Name	Company Name
Patient's Name (if other than employee)	

1. 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.)
2. Probable duration of medical condition or need for treatment: \_\_\_\_\_
3. *Attachment A: Definitions* 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?  
 Yes     No
4. 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 the essential functions of the employee's position? (Answer after reviewing the attached job description provided by the employee that includes the essential functions of the employee's position.)  
 Yes     No
  - c. If yes to either 4a or 4b, please provide proposed or recommended accommodations:  
 \_\_\_\_\_  
 \_\_\_\_\_
5. If the certification is for the care of the employee's family member, please answer the following:
  - a. The patient does, or will, require assistance for basic medical, hygiene, nutritional needs, safety or transportation.  
 Yes     No
  - b. After review of the 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
6. Estimate the period of time care will be needed or during which the employee's presence would be beneficial: \_\_\_\_\_
7. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule:
  - a. 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?  
 Yes     No
  - b. If the answer to 7a 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.  
 \_\_\_\_\_

Signature of Health Care Provider <b>X</b>	Date
Signature of Employee <b>X</b>	Date

## Medical Certification - FMLA / CFRA

### Employee's Statement Regarding Seriously Ill Family Member

To be completed and signed by the employee needing family leave to care for a seriously ill family member. Employee should provide this section to the health care provider under separate cover. **This information is not to be provided to the employer.**

When family care leave is needed to care for a seriously ill family member, the employee must state the care he/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:

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Signature of Employee <b>X</b>	Date
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### Attachment A: Definitions

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 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:

- Treatment two or more times by a health care provider (for FMLA only, the two treatments must occur within 30 days \*\*\*), 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
- 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.
- For FMLA only, the employee’s first treatment must occur within 7 days of first day of incapacity. \*\*\*

#### 3. **Pregnancy**

A 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.)

#### 4. **Chronic Conditions Requiring Treatment**

A chronic condition which:

- a. Requires periodic visits (for FMLA ONLY periodic means at least two times per year \*\*\*) 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 that 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 treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).

\*\*\* California law does not include these time limitations. If a leave is FMLA/CFRA, follow the California law without these time limitations.