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

Please complete this confidential form and return it to: Human Resources at 5150 N Maple Avenue, M/S JA41, Fresno, CA 93740-8026 Phone: 559 278-2032 Fax: 559 278-4275

Employee Name: _____ (PRINT NAME) HR Contact:_____(NAME) Phone:_____

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____ If family member is your son/daughter, provide date of birth:_____

Describe the care you will provide to your family member and estimate leave needed to provide care: _____

_____

_____

Employee Signature: _____ Date: _____

For Completion by the Health Care Provider

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA/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" are not sufficient to determine FMLA/CFRA coverage.** Limit your responses to the condition for which the employee is seeking leave. Note: the health care provider is not to disclose the underlying diagnosis without the consent of the patient. In addition, the ***Genetic Information Nondiscrimination Act of 2008*** **(GINA)** prohibits employers and other entities covered by **GINA** title ii from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. **"genetic information"** as defined by **GINA**, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the categories (1-6) described below under the 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**
- **If yes, please check the appropriate category: (1)____ (2)____ (3)____ (4)____ (5)____ (6)____**

DEFINITION OF SERIOUS HEALTH CONDITION

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:
(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. [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:
(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.).

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 there from) 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).

NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT.

1) Date medical condition or need for treatment commenced: _____

2) **REQUIRED INFORMATION:** Based on the patient's medical history and your knowledge of the medical condition, estimate the type of absences the employee's presence would be beneficial **(A, B or C)** to care for family member:

A. ❑ **OFF FULL-TIME for the period of** _____ to _____

B. ❑ **OFF INTERMITTENTLY for the period of**_____ to _____

Please estimate how often (Frequency) and how long (Duration) each episode will last.

Examples: Frequency = 3 - 4 times per year, Duration = 1-2 days per episode
Frequency = 1 - 2 times per month, Duration = 2-3 hours per episode

✓**Check which applies (year, month, week):**

Frequency: How many times_____ ❑ per **Year** **OR** ❑ per **Month** **OR** ❑ per **Week**

✓ **Check which applies (hours or days):**

Duration: How long per episode _____ ❑ hour(s) **OR** ❑ day(s)

Comments:_____

C. ❑ **PARTIAL WORK SCHEDULE for the period of** _____ to _____

Number of hours per day_____ Work Schedule: M T W TH F Sat Sun

Comments:_____

3) **NEEDS OF PATIENT**: Does or will the patient require medical assistance for basic medical, hygiene, nutritional needs, safety or transportation for appointments? ❑ **YES** or ❑ **NO**

Comments:_____

4) **EMPLOYEE PARTICIPATION IN PROGRAM:** After reviewing the employee's signed statement, does the condition warrant the participation of the employee? ❑ **YES** or ❑ **NO**

Comments:_____

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PHYSICIAN INFORMATION:

Signature of Health Care Provider: _____ Date: _____

Print Name of Health Care Provider _____Phone Number:_____

Business address _____ City/State/Zip_____

Type of Practice/Medical Specialty _____Fax Number:_____