CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE
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
5150 N Maple Ave M/S JA71 Fresno, CA 93740-8026 Phone: 559 278-2032 Fax: 559 278-4275

Employee (Patient) Name: _____ HR Contact_____
(PRINT NAME) (NAME)

Employee's Job title: _____Regular work schedule:_____
(WORKDAY/TIME)

Job description of employee's essential job functions is attached: ❑Yes ❑ No

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.

DEFINITION OF SERIOUS HEALTH CONDITION

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) 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 [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.

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).

(Complete Reverse Side)

1. The **reverse side 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).

- o Does the patient's condition qualify under any of the categories described? ❑Yes ❑ No
- o If yes, please check the appropriate category: (1)____ (2)____ (3)____ (4)____ (5)____ (6)____

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

3. PERIOD OF TIME REQUIRED: Based on the patient's medical history and your knowledge of the medical condition, estimate the type of absence and period.

❑ **Off full-time for the period of** _____ to _____

Comments:_____

❑ **Intermittently for the period of**_____ to _____

Estimate how often (Frequency) and how long each episode of patient incapacity will last (Duration).

(For example: Frequency = 1-2 times per 2 weeks, Duration = 2-3 hours)

*** Frequency**:_____ times per _____ week(s); per____ month(s); or " Other": _____

* **Duration:** _____ hours or _____ day(s)

Comments:_____

❑ **Work on a reduce work schedule for the period of** _____ to _____

Reduce hours from _____ to _____hours on: M T W TH F Sat Sun

Comments:_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include **symptoms or any regimen of continuing treatment**.)

_____

_____

5. If employee is able to work intermittent or at a reduce schedule, is employee able to perform their current job duties during scheduled work hours? (See attach job duties) ❑Yes ❑ No

If yes—are there any essential functions the employee is not able to perform? (Answer after reviewing job description and discussing with employee)

_____

6. Will the employee need to attend follow-up treatment or appointments because of the employee's medical condition? ❑Yes ❑ No

If yes—Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

_____

7. 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: _____ **Date:** _____

Print Name of Health Care Provider _____**Phone Number:**_____

Business address _____ **City/State/Zip**_____

Type of Practice/Medical Specialty _____**Fax Number:**_____