CERTIFICATION OF HEALTH CARE PROVIDER FOR PATERNITY LEAVE
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 Name: __________________________________  HR Contact______________________________
(Print Name)                        (NAME)

I am requesting time for bonding with my child under the FMLA/CFRA Program. I have completed the California State
University Family and Medical Leave (FMLA/CFRA) Notice and Request form. I will provide Human Resources with a
medical note or the certification below by the document deadline.

Employee Signature: __________________________________________________ Date: ________________

Request for Medical Note

Instructions: The Health Care Provider may complete this form in lieu of a medical note. If a medical note is
provided, it must include the information below.

Patient’s Name: ____________________________________________________________

Due Date: _________________________________________________________________

Period of Disability: __________________________________________________________

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: _____________