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. Room 211, M/S JA41 Fresno, CA 93740-8026 Phone: 559 278-2032 Fax:559 278-4275

Employee (Patient) Name: _____HR Contact_____Phone:_____
(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.

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)____**

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 [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).

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

2. **PERIOD OF TIME REQUIRED**: Based on the patient's medical history and your knowledge of the medical condition, select the type of absence and period employee will require: FULL, INTERMITTENT,OR PARTIAL. If more than one applies to transition employee back to work from a full leave, please specify.

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 = 1 - 2 times per month, Duration = 2-3 hours per episode
Frequency = 3 - 4 times per year, Duration = 1-2 days 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. Will the employee need to attend follow-up treatment or appointments because of the employee's medical condition?
❑ **YES** ❑ **NO**

If **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. (e.g. yearly, monthly, weekly, every six months)

_____

4. If employee is able to work intermittent or at a reduce schedule, can employee perform their current job duties during their scheduled work hours? ❑**YES** ❑ **NO**

If yes—are there any essential functions the employee is not able to perform? (Please review job description and discuss with employee.)

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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:**_____ **5/14**