CERTIFICATION OF HEALTH CARE PROVIDER
For Employee's Serious Health Condition
(California Family Rights Act/Family Medical Leave Act)

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) provide that an employee seeking FMLA/CFRA leave due to a serious health condition may be required to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Like all forms relating to medical inquiries, this form should be treated as a confidential medical record and kept in the individual's Employee Health file.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions (either take these from the individual's job description or attach a copy): _____

_____

_____

Check box if job description is attached: ☐

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) permit an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/CFRA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA/CFRA request. Your employer must give you at least 15 calendar days to return this form. If you are seeking a pregnancy disability leave, this form is optional, and you may submit a doctor's note instead that includes the information requested in Part C of this form.

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTION to the HEALTH CARE PROVIDER: Your patient has requested leave under the The Family and Medical Leave Act (FMLA) and/or the California Family Rights Act (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" may not be sufficient to determine FMLA/CFRA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Please do not to disclose the underlying diagnosis, illness, injury, impairment, or physical or mental condition. 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 the law. To comply with GINA, 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.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____

E-mail: _____

Patient's Name: _____

If the request is for Pregnancy Disability Leave, you may skip directly to Part C on page 5 of this form.

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If so, date(s) of admission: _____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition?

☐ Yes ☐ No

Was medication, other than over-the-counter, prescribed? ☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No If so, state the nature of such treatments and expected duration of treatment: _____

_____

2. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition?

☐ Yes ☐ No If so, identify the job functions the employee is unable to perform:

_____

_____

_____

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include any regimen of continuing treatment or the use of specialized equipment). **Do NOT disclose the patient's underlying diagnosis, illness, injury, impairment, or physical or mental condition.**

_____

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

4. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

If so, estimate the beginning and ending dates for the period of incapacity: _____

_____

5. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

If so, are the treatments or the reduced number of hours of work medically necessary?

☐ Yes ☐ No

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

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

6. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

Is it medically necessary for the employee to be absent from work during the flare-ups?

☐ Yes ☐ No If so, explain: _____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next six months (for example, 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) _____ per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider Date

PART C: COMPLETE THIS SECTION FOR PREGNANCY-RELATED DISABILITY LEAVES ONLY

Use the information provided by the employer in Section I to answer these questions. If the employer fails to list the employee's essential functions or provide a job description, answer these questions based upon the employee's own description of her job functions.

Please certify that, because of this patient's pregnancy, childbirth, or a related medical condition (including, but not limited to, recovery from pregnancy, childbirth, loss or end of pregnancy, or post-partum depression), this patient needs (check all appropriate category boxes):

☐ **Time off for medical appointments.**

Specify when and for what duration:

_____

☐ **A disability leave.** [Because of a patient's pregnancy, childbirth or a related medical condition, she cannot perform one or more of the essential functions of her job or cannot perform one or more of these functions without undue risk to herself, to her pregnancy's successful completion, or to other persons.]

_____

Beginning (Estimate):

_____

Ending (Estimate):

_____

☐ **Intermittent leave.** Specify medically advisable intermittent leave schedule:

_____

Beginning (Estimate):

_____

Ending (Estimate):

_____

☐ **Reduced work schedule.** Specify medically advisable reduced work schedule:

_____

Beginning (Estimate):

_____

Ending (Estimate):

_____

☐ **Transfer to a less strenuous or hazardous position or to be assigned to less strenuous or hazardous duties** [specify what would be a medically advisable position/duties].

_____

Beginning (Estimate):
_____

Ending (Estimate):
_____

☐ **Reasonable accommodation(s).** [Specify medically advisable needed accommodation(s).
These could include, but are not limited to, modifying lifting requirements, or providing more frequent breaks, or providing a stool or chair.]

_____

Beginning (Estimate):
_____

Ending (Estimate):
_____

Name, license number and medical/health care specialty [printed] of health care provider.

_____
_____
_____

_____ _____

Signature of Health Care Provider Date