CERTIFICATION OF HEALTH CARE PROVIDER

for California Family Rights Act (CFRA)

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. *To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information.* "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

1. Employee Name: _____

2. Patient's Name (if other than employee): _____

   Patient's Relationship to Employee: _____

   Is patient under 18 or an adult dependent child?: _____ Yes _____ No

3. Date medical condition or need for treatment commenced. (Do not disclose the underlying diagnosis without consent of the patient.) _____

4. Probable duration of medical condition or need for treatment: _____

5. Does the patient's condition qualify as a serious health condition? (Please see page 3 for a description of what constitutes a "serious health condition" under applicable law.) _____ Yes _____ No

6. If the certification is for the serious health condition of the employee, please answer the following:

   Is the employee able to perform work of any kind? (If "No," skip next question) _____ Yes _____ No

   Is employee unable to perform any one or more of the essential functions of employee's position? (Please answer after reviewing employer's statement of essential function of employee's position, or, if such a statement has not been provided, after discussing with employee.) _____ Yes _____ No

7. If the certification is for the care of the employee's family member, please answer the following:

   Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? _____ Yes _____ No

   After review of the employee's signed statement (item 10), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.) _____ Yes _____ No

8. Estimate the period of time the employee's family member will need care during which the employee's presence would be beneficial to participate in care for the employee's family member:

_____

9. Please answer the following questions only if the employee is asking for intermittent leave or a reduced work schedule:

Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee or family member? _____ Yes _____ No

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: ____ times per ____week(s) ____month(s) *Duration*: ____hours or ____day(s) per episode

Reduced Schedule Leave: Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee or family member? _____ Yes _____ No

If yes, please indicate the part-time or reduced work schedule the employee needs:

Frequency: ____hour(s) per day; ____days per week, from _____ through _____.

Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services? _____ Yes _____ No

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: ____ times per ____ week(s) ____ month(s) *Duration*: ____ hours or ____ day(s) per apt./treatment

10. **For employee use:** If you are seeking leave to care for a seriously-ill family member, please provide a description of the care you will provide for your family member.

_____

_____

_____

_____

EMPLOYEE SIGNATURE **DATE**

Health Care Provider Name (print): _____

_____

HEALTH CARE PROVIDER SIGNATURE DATE

SERIOUS HEALTH CONDITION

"Serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

HOSPITAL CARE

Inpatient care 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. A person is considered an "inpatient" when a health care facility formally admits them to the facility with the expectation that they will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

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.

PREGNANCY

Any period of incapacity due to pregnancy or for prenatal care.

An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA

CHRONIC CONDITIONS REQUIRING TREATMENT

A chronic condition, which:

1. Requires periodic visits for treatment by a health care provider, or by a nurse of 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.).

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.

MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) 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), or kidney disease (dialysis).