CITY AND COUNTY OF SAN FRANCISCO

Certification of Health Care Provider under the
Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA) And
Pregnancy Disability Leave (PDL)

Use This Form For A Family Member's Serious Health Condition
PLEASE GIVE THIS FORM TO YOUR FAMILY MEMBER'S
HEALTH CARE PROVIDER AFTER COMPLETING SECTION A

Section A: To Be Completed By the Employee

Employee's Name: _____Classification: _____

Department: _____

Personnel Official's Name: _____ Telephone Number: _____

Patient/Family Member's Name: _____ Relationship: _____

Section B: Instructions to the Health Care Provider

Certification of Health Care Provider of a Serious Health Condition
(Family and Medical Leave Act (FMLA) of 1993, California Family Rights Act (CFRA).)

Dear Health Care Provider:

The above-named employee has requested a leave of absence or intermittent leave for the condition of a family member, which may qualify as a protected leave under the FMLA and/or CFRA. This medical certification form will provide us with information needed to determine if the employee is eligible for leave under FMLA and/or CFRA. Sections C-F must be completed by you and returned to the department by the employee or your office. **In all cases, it is the employee's responsibility to ensure that sufficient medical certification is provided to the employer.**

INSTRUCTIONS

The information sought on this form relates only to the family member's condition for which the employee is taking leave. For the purposes of this form, "incapacity" is defined as the inability to work, attend school, or perform other regular daily activities due to the serious health condition itself, treatment of the serious health condition, or recovery from the condition. "Treatment" includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include taking over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or other similar activities that can be initiated without a visit to a health care provider.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. 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 individual's family member sought or received genetic services, and genetic information of a fetus to be 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.

Section C: Definition of a Serious Health Condition

The definitions below describe what is meant by a "serious health condition" under the FMLA and/or CFRA. Does the patient's condition(s) qualify under any of the categories described? If so, please check the appropriate category.

☐ **CATEGORY 1: In-Patient Care**

Any period of incapacity or treatment connected with 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.

☐ **CATEGORY 2: Absence Plus Treatment**

A period of incapacity of more than three (3) consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, which also involves:

a) Treatment two (2) or more times, within 30 days of the first day of incapacity, by a health care provider, by a nurse 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
b) Treatment by a health care provider on at least one (1) occasion, which results in a regimen of continuing treatment under the supervision of the health care provider, e.g., prescribed medication.

☐ **CATEGORY 3: Pregnancy or Prenatal Care**

Any period of incapacity due to pregnancy, or for prenatal care. Expected delivery date: _____

☐ **CATEGORY 4: Chronic Conditions**

Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:

a) 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;
b) Continues over an extended period of time, including recurring episodes of a single underlying condition; and
c) May cause episodic rather than a continuing period of incapacity, e.g., asthma, diabetes, epilepsy, etc.

☐ **CATEGORY 5: Permanent or 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 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.

☐ **CATEGORY 6: Conditions Requiring Multiple Treatments**

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, for:

a) Restorative surgery after an accident or other injury; or
b) A condition that would likely result in a period of incapacity of more than three (3) consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

☐ **NO CATEGORY APPLIES**

Section D: Supporting Medical Facts

Note: The health care provider is not to disclose the underlying diagnosis without the patient's consent.

1. State the approximate date the condition began: _____

2. State the probable duration of the condition or need for treatment: _____

3. State the probable duration of the patient's incapacity, if different from the duration of the condition:

_____

4. After review of the employee's signed statement (see attached Request for Leave form), 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

5. Does (or will) the patient require assistance from the employee with basic medical, hygiene, nutritional, safety, transportation needs or the participation of physical or psychological care? ☐ Yes ☐ No

Section E: Amount of Leave Requested
(Only Check and Complete the Section(s) That Apply)

☐ CONTINUOUS LEAVE

The patient will be incapacitated for a continuous period of time and will require the employee to be on **CONTINUOUS LEAVE** for the patient's treatment and/or recovery.

Estimate the beginning and ending dates for the period of incapacity: From _____ through _____

☐ INTERMITTENT LEAVE

It is medically necessary for the employee to take **INTERMITTENT LEAVE** because the family member's serious health condition causes episodic incapacity due to flare-ups or urgent care.

a. Estimate the frequency of flare-ups or the need for urgent care:

Frequency: _____ times per _____ week **/** month **/** year (circle one)

b. Estimate the duration of time the employee is required to care for the family member on each occasion:

Duration: _____hours / days per incident (circle one)

Dates flare-ups or need for urgent care may occur: From _____ through _____

☐ TREATMENT OR APPOINTMENTS

It is medically necessary for the employee to attend or transport the family member to follow- up **TREATMENT** or **APPOINTMENTS** because of the family member's serious health condition.

Scheduled Treatment/Appointments: _____times per _____ week / month / year (circle one)

Estimate dates, times and length of scheduled appointments: _____

_____

_____

Continue To Next Page

Section E: Amount of Leave Requested
(Continued)

☐ PART-TIME SCHEDULE

It is medically necessary for the employee to work a **PART-TIME SCHEDULE** due to the family member's serious health condition.

Indicate the part-time schedule the employee needs:

Employee can work _____ hours per day for_____ days per week from _____ through _____

Additional Comments:_____

_____

_____

_____

Section F: Definition of Health Care Provider

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as a

a. doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker, physician's assistant, who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.
b. any provider the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.

_____ _____
(Signature of Health Care Provider) (Date)

_____ _____
(Print Name of Health Care Provider) (License No.)

_____ _____
(Address) (Phone No.)

Thank you for your assistance.