LOS ANGELES UNIFIED SCHOOL DISTRICT
Family and Medical Leave Act (FMLA)/California Family Rights Act (CFRA)
Pregnancy Disability Leave (PDL)

Health Care Provider Certification
Employee or Family Member Serious Health Condition

SECTION I: For Completion by the SUPERVISOR

Please read and complete Section I before providing this form to your employee.

The Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA) and Pregnancy Disability Leave (PDL) state that an employer has the authority to require an employee to submit a medical certification issued by the employee's health care provider, if the employee is seeking a qualifying protected leave. You may not ask an employee to disclose information other than what is permitted under the applicable regulations. Employers must maintain confidential leave records that document an employee's medical certifications/recertification, separately from the employee's personnel files.

a) School Site/Division: _____

b) Supervisor/Administrator: _____ Date: _____

c) Employee Name: _____ Employee #: _____

d) Employee's Job Title: _____

e) Regular Work Schedule: _____

f) Employee's Essential Job Functions: _____

☐ Check if job description is attached.

SECTION II: For Completion by the EMPLOYEE

Please read and complete Section II before presenting this form to your medical provider.

FMLA, CFRA, and PDL state that an employer has the authority to require an employee to submit a timely, complete and sufficient medical certification to support a request for FMLA, CFRA, or PDL leave. Submittal of the medical certification is required by LAUSD in order to obtain and/or retain leave protections. Failure to provide a complete and sufficient medical certification may result in the denial of a request for protected leave. Employees have at least 15 calendar days to return this form.

The Genetic Information Nondiscrimination Act of 2008, Title II (GINA) prohibits employers and other entities covered by GINA, from requesting genetic information of an individual or family member, except as specifically allowed by this law. To comply with GINA, do not provide any genetic information when responding to this request for medical information.

Employee's full name: _____

Patient's name if other than employee: _____

Patient's relationship to employee: _____

Employee's Signature: _____ Date: _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

Please complete Section III and sign Page 3 of this document.

Please provide complete answers to all applicable questions below. Several questions seek a response regarding the frequency or duration of a condition and/or treatment. Your answer should be your BEST ESTIMATE based upon your examination of the patient and your prognosis. Please be as specific as possible, noting that terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to grant leave protections. Limit your responses to address only the condition for which the employee is seeking a protected leave.

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition or need for treatment: _____

2. Check definitions of serious health conditions below (A-F) that apply. (Detailed list attached)

   _____ A. In-patient care in a hospital, hospice, or residential medical care facility

   If yes, provide date(s) of admission: _____

   _____ B. Serious incapacity of more than 3 consecutive calendar days + 2 treatments

   _____ C. Incapacity causing absence due to pregnancy or pre-natal care

   If yes, expected delivery date: _____

   _____ D. Serious chronic condition causing incapacity and requiring treatments

   _____ E. Serious permanent condition or serious long-term condition

   _____ F. Multiple treatments for serious health condition

3. Use the information provided by the Supervisor 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.

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

   A. Is the employee unable to perform any of his/her job functions due to the condition?
      Yes ☐ No ☐

      If yes, identify the job functions the employee is unable to perform:

      _____

      _____

      _____

   B. 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, transportation, psychological comfort and/or arranging for third-party care for the family member? Yes ☐ No ☐

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PART B: AMOUNT OF LEAVE NEEDED

1. **Single Continuous Period of Time**: Is it medically necessary for the employee to be off work due to serious health condition of the employee or family member? Yes ☐ No ☐

   If yes, estimate the beginning and ending dates for the period of incapacity from:

   _____ through _____.

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

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

   _____ Hours per day; _____Days per week; from _____ through_____

   NOTES: _____

3. **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? Yes ☐ No ☐

   If yes, estimate treatment frequency and treatment duration (including recovery period)

   Frequency: _____ times per _____week(s) or _____ month(s)

   Duration: _____ hour(s) or _____ day(s) per appointment/treatment

   NOTES: _____

4. **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, 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 need (e.g., 1 episode every 3 months lasting 1 -2 days):

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

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

   NOTES: _____

Health Care Provider Verification

Please provide the following information pertaining to your practice:

Your Name_____

Your Name as Health Care Provider_____ Degree_____

Specialty/Type of Practice_____ License No._____

Type of License_____

Address_____

Zip Code_____ Telephone_____

Endorse the following statement: "I certify that I am the treating health care provider for the above-named patient who is under my professional care. All of this information is true and correct to the best of my knowledge."

Original Signature (no stamp):_____ Date:_____

Serious Health Condition

A. 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 him or her to the facility with the expectation that he or she 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.

B. Absence Plus Treatment
   a. A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
      i. 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
      ii. 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.

C. Pregnancy; any period of incapacity due to pregnancy or for prenatal care

D. Chronic Conditions Requiring Treatment
A chronic condition 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.)

E. 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.

F. Multiple Treatments (Non-Chronic Conditions)
A 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 (3) 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).