# CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

Family and Medical Leave Act (FMLA) & California Family Rights Act (CFRA)

**Purpose of this Form:** The below-named employee has requested a leave of absence to care for a family member with a health condition, which may qualify as a protected leave under the FMLA and/or CFRA. This form will provide the University with the information necessary to determine if the requested leave is a qualifying reason under FMLA and/or CFRA.

**Employee Instructions:** Please complete and sign Section II before giving this form to your family member or their health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA and/or CFRA leave due to your family member's serious health condition. Providing this completed form is required to obtain or retain FMLA and/or CFRA protections for your leave. ***This form should be completed and returned to Benefits in the Department of Human Resources within 15 calendar days of the University's request for this information.*** Failure to provide a complete or sufficient Certification of Health Care Provider form to the University may delay or result in a denial of your leave request. If you cannot return this completed form within 15 days please contact Anne Mota (x1934, amota@scu.edu) or Caroline Zelaya (x5750, czelaya@scu.edu) with the reason for the delay.

Your Name (Employee):_____
First Middle Last

**SECTION I: For Completion by Santa Clara University:**

Employee's name: _____

Employee's department: _____

University contact: Anne Mota, Benefits Specialist, Santa Clara University
Ph. (408) 551-1934, Fax (408) 554-4360, amota@scu.edu

Caroline Zelaya, Benefits Specialist, Santa Clara University
Ph. (408) 554-5750, Fax (408) 554-4360, czelaya@scu.edu

**SECTION II: For Completion by EMPLOYEE**

Name of family member for whom you will provide care: _____

If family member is your child, date of birth: _____

Relationship of family member to you: _____

If the child is 18 years of age or older, is the child incapable of self-care because of mental or physical disability?

☐ Yes ☐ No

Describe care you will provide to your family member and estimate the duration of leave needed to provide care.

Are you requesting leave on an intermittent or reduced schedule basis? ☐ Yes ☐ No

If yes, please describe the leave schedule you are requesting

Employee Signature: _____ Date: _____

**SECTION III: For Completion by the HEALTH CARE PROVIDER.**
**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA and/or CFRA to care for your patient. 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 employee. 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. **NOTE: DO NOT DISCLOSE THE EMPLOYEE'S UNDERLYING DIAGNOSIS WITHOUT THEIR CONSENT.**

**THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA):** The Genetic Information Nondiscrimination Act of 2008 (GINA) 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 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 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.

**Please limit your responses to the condition for which the patient needs the employee's care.**
Provider's name and business address:

Telephone: _____ Fax _____

**PART A: MEDICAL FACTS**

1. Approximate date condition or need for treatment commenced: _____
   Probable duration of condition or need for treatment: _____

2. The attached sheet describes what is meant by a "serious health condition" under both the FMLA and CFRA. Does the employee's condition qualify as one of the types of serious health conditions described?
   ☐ Yes ☐ No

**PART B: AMOUNT OF CARE NEEDED**
When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety and transportation needs, or the provision of physical or phychological care:

1. Please estimate the beginning and ending dates for the duration of the condition:
   From _____ To_____

   During this time, does the patient's condition warrant the participation of the employee? (Please refer to the employee's statement of care in Section II in answering this question) ☐ Yes ☐ No

2. If the employee has requested leave on an intermittent or reduced schedule leave basis (see employee's response in Section II, question 2), is it medically necessary for the patient to receive care on an intermittent or reduced schedule basis, including any time for recovery?
   ☐ Yes ☐ No
   If yes, estimate the hours the patient needs care from the employee:

   _____ hours per day _____ days per week From: _____ Through: _____

**PART C: SIGNATURE OF HEALTH CARE PROVIDER**

_____ _____
Signature Date

## Serious Health Conditions

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Inpatient 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. **Incapacity of More Than 3 Consecutive Days *PLUS* Continuing 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:

   (a) 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**
   (b) 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 (*e.g.*, a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). Note: This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (*e.g.,* bed rest, exercise, drinking fluids).

3. **Pregnancy (only covered under FMLA)**
   Any period of incapacity due to pregnancy, childbirth, or related medical conditions, including but not limited to severe morning sickness and prenatal care.

4. **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. . .)

5. **Permanent/Long-Term Conditions Requiring Supervision**
   A period of incapacity that 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 recover therefrom) by a health care provider or by a provider of healthcare 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).