



## Certification of Health Care Provider for Family Member California State University Family Medical Leave (CSU FML)\*

### SECTION I: For Completion by the **EMPLOYEE**

INSTRUCTIONS: Please complete Section I before giving this form to your medical provider. The CSU FML permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for CSU FML leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of CSU FML protections. 29 U.S.C. §§ 2613, 2614(c) (3). Failure to provide a complete and sufficient medical certification may result in a denial of your CSU FML request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee name: \_\_\_\_\_

Patient name: \_\_\_\_\_

Patient Relationship: \_\_\_\_\_

When family care leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

### SECTION II: For Completion by the **HEALTH CARE PROVIDER**

INSTRUCTIONS: Your patient has requested leave under the CSU FML. 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 CSU FML 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:** The health care provider is not to disclose the underlying diagnosis without the consent of the patient. 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 this law. To comply with this law, 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: (\_\_\_\_\_) \_\_\_\_\_

The list below describes what is meant by a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following.

#### Please check the appropriate category

☐ **Hospital 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.

☐ **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:

- 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
- 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** [NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.] Any period of incapacity due to pregnancy, or for prenatal care.

☐ **Chronic Conditions Requiring Treatment**

A chronic condition which:

- 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;
- Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- 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), kidney disease (dialysis).

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- Approximate date condition commenced: \_\_\_\_\_
  - Probable duration of condition: \_\_\_\_\_
  - Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? \_\_\_\_Yes \_\_\_\_No
  - After review of the employee's statement (see Section I), does the condition warrant the participation of the employee? \_\_\_\_Yes \_\_\_\_No

Will the patient be incapacitated for a **continuous** period of time due to their medical condition, including any time for treatment and recovery?

\_\_\_\_Yes \_\_\_\_No If **YES**, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

- Estimate the period of time care needed or during which the employee's presence would be beneficial: \_\_\_\_\_
- Will the patient require the employee's care on an **intermittent or reduced schedule** basis, including any time for recovery? \_\_\_\_Yes \_\_\_\_No

If **YES**, estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ Hour (s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

- Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal activities? \_\_\_\_Yes \_\_\_\_No
- Is it medically necessary for the employee to be absent from work during the patient's flare-ups? \_\_\_\_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 have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) OR \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours OR \_\_\_\_\_ day(s) per episode

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

The form is to be returned to Human Resources at [leaves@csumb.edu](mailto:leaves@csumb.edu)  
For questions please call Linda Schaedle at 831-582-3584