

# Family and Medical Leave Certification

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

Patient (if other than employee): \_\_\_\_\_ Relation to employee: \_\_\_\_\_

Begin date of requested leave: \_\_\_\_\_ End date of requested leave: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Telephone: \_\_\_\_\_

If leave is for my own serious health condition, I authorize my health care provider to provide my diagnosis.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## HEALTH CARE PROVIDER AREA

### Dear Health Care Provider:

Our employee has requested leave under the provisions of Federal and/or California family and medical leave statutes for:

- o his or her own serious health condition; or
- o for the purpose of caring for your patient (who is a parent, child, or spouse, or domestic partner of our employee).

In order for the University Corporation at Monterey Bay to determine whether this leave qualifies for family and medical leave under Federal and/or State law, please complete the brief Health Care Provider section on the reverse side of this letter.

***Do not release the employee's diagnosis unless authorized by the employee (see "Employee Section" of this form for authorization).*** If you have any questions, please phone the supervisor listed on the reverse side. Thank you for your assistance.

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### IF LEAVE IS BECAUSE OF EMPLOYEE'S SERIOUS HEALTH CONDITION

Does this employee have a serious health condition? (See next page for definition): \_\_\_Yes \_\_\_No

If authorized, what is employee's diagnosis? \_\_\_\_\_

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When did the serious health condition begin? \_\_\_\_\_

Please review the attached job description. Is this employee able to perform the functions of his or her job? \_\_\_Yes \_\_\_No

If intermittent leave or a reduced work schedule is being considered, is it medically necessary?  
\_\_\_ Yes \_\_\_ No

If so, please describe the recommended schedule.

What is the anticipated return to work date? \_\_\_\_\_

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**IF LEAVE IS BECAUSE OF A SERIOUS HEALTH CONDITION OF  
EMPLOYEE'S FAMILY MEMBER**

Does employee's family member have a serious health condition? \_\_\_ Yes \_\_\_ No  
(See next page for definition)

When did the serious health condition begin? \_\_\_\_\_

Is the employee's presence necessary or would it be beneficial to the patient? \_\_\_ Yes \_\_\_ No  
(This may include psychological comfort and/or arranging for third-party care for the family member.)

If intermittent leave or a reduced work schedule is being considered, is it medically necessary?  
\_\_\_ Yes \_\_\_ No

If so, please describe the recommended schedule.

What is the anticipated return to work date? \_\_\_\_\_

Name of Health Care Provider: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address of Health Care Provider: \_\_\_\_\_

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Signature of Health Care Provider: \_\_\_\_\_ Date \_\_\_\_\_

Place address stamp here.

**RETN: 3YEARS**

**A serious health condition is any illness, injury, impairment or physical or mental condition that involves:**

- Any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or
- Continuing treatment by a health care provider for one or more of the following:
  - Any period of incapacity for more than three consecutive calendar days that also involves treatment two or more times or treatment on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.
  - Any period of incapacity due to pregnancy, for prenatal care.
  - Any period of incapacity due to a chronic serious health condition that:
    - requires periodic visits for treatment;
    - continues over an extended period of time; and
    - may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
  - Any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease).
  - Any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition such as cancer or kidney disease.

**A serious health condition is NOT:**

- Allergies, stress, or substance abuse unless inpatient hospital care is required, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health condition; or
- Voluntary treatment or surgery unless inpatient hospital care is required.

*Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker 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. A health care provider also is any provider from whom the University or the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.*