



California State University, Monterey Bay

University Personnel

Tide Hall

100 Campus Center, Seaside, CA 93955-8001 (831) 582-3389, FAX: (831) 582-3572

Family Medical Leave – Certification of Health Care Provider

1. **Employee’s Name:** _____
2. **Patient’s Name** (if other than employee): _____
3. **Date medical condition or need for treatment commenced:** (NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT):

4. **Probable duration of medical condition or need for treatment:** _____
5. Please refer to **DEFINITION OF A “Serious Health Condition”** at the bottom of this document, as defined under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). **Does the patient’s condition qualify under any of the categories described? If so, please check the appropriate category:**
(1) (2) (3) (4) (5) (6)
6. **If the certification is for the serious health condition of the EMPLOYEE, please answer the following:**
 - **Is the employee able to perform work of any kind?** (If “No”, skip to next question.)
Yes No
 - **Is the employee unable to perform any one or more of the essential functions of employee’s position?** (Answer after reviewing statement from employer of essential functions of employee’s position, or, if none provided, after discussing with employee.)
Yes No
7. **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 or transportation?**
Yes No
 - **After review of the employee’s signed statement (See Item 10 below), 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
8. **Estimate the period of time care is needed or during which the employee’s presence would be beneficial:**

9. **Please answer the following question only if the employee is asking for INTERMITTENT LEAVE or a REDUCED WORK SCHEDULE:**
 - **Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee’s normal work schedule in order to deal with the serious health condition of the employee or family member?**
Yes No
 - **If the answer to 9 is yes, please indicate the estimated number of doctor’s visits and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider:**



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ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE AND PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER

10. 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:

11. Signature of health care provider: _____ Date: _____

Print Physician's Name: _____

Physician's Phone Number: _____

12. Signature of Employee: _____ Date: _____

DEFINITION OF A "SERIOUS HEALTH CONDITION"

An illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care:**

Inpatient care (i.e., an overnight stay) in the 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. **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
- Pregnancy (NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.)

3. **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.

4. **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.).

5. **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.

6. **Multiple Treatment (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 intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).