

**Physician or Practitioner Medical Certification Medical Leave, FMLA, CFRA.
Family Member – Serious Health Condition**

TO BE COMPLETED BY THE TREATING PHYSICIAN OR HEALTH CARE PROVIDER ONLY.

1. Employee Name: _____ Patient's Name: _____
2. Patient's Relationship to Employee: _____
3. Date Condition Commenced: ____ / ____ / ____ Date you began treating patient: ____ / ____ / ____
4. Does the patient have a "serious health condition" as described on the reverse of this form? If the patient's condition qualifies under any of these categories, please check the applicable number:
(1) (2) (3) (4) (5) (6) or none of the above .

Check Yes or No in the box below, as appropriate:

Yes No

5. Is inpatient hospitalization of the family member (patient) required?
6. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
7. 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 family member.)

If the answer is yes to 5, 6, or 7, please estimate the period of time.

Duration: Start ____ / ____ / ____ End ____ / ____ / ____

Please answer the following question only if the employee is asking for intermittent leave or reduced work schedule.

Yes No

8. Is it medically necessary for the employee to be off work on an intermittent basis or reduced work schedule in order to deal with the serious health condition of a family member?
9. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule.

10. **Yes** **No** Is this certification for an ongoing leave that needs to be extended (recertification)?

Print Physician Name

Physician Signature

Specialty

Date

Address

Telephone

ITEM 10 TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY LEAVE.

10. State the care you will be providing 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 leave schedule:

Employee Signature : _____ Date: ____ / ____ / ____

A “Serious Health Condition” under both the Federal and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) means 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 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. 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 involves:

- (1) Treatment¹ two or more times by a health care provider, by a nurse or physician’s assistant under direct supervision of a healthcare provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider. These two visits to the health care provider must occur within 30 days of the beginning of the period of incapacity, and the first visit must take place within seven days of the first day of incapacity; or
- (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment² under the supervision of the health care provider. This visit must take place within the first seven days of the first day of incapacity.

3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatment

A chronic condition which:

- (1) Requires periodic visits for treatment by a health care provider (at least two visits to a health care provider per year) or by a nurse physician’s assistant under direct supervision of a health care provider;
- (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (3) 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 must be under the counting 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 recovery therefrom) by a health care provider or by a provider of health care services under the 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), and kidney disease (Dialysis).

¹ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

² A regimen of treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen or treatment does not include taking over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.