FMLA / CFRA

Certification of Family Member's Serious Health Condition

Important Note: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) 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 law. To comply with CalGINA, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by CalGINA includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic information" does not include information about an individual's sex or age.

To be completed by the EMPLOYER:

1. Employer Name/Contact: _____
2. Employee Name: _____
3. Employee Title: _____
4. Employee regular work schedule: _____
5. Employee's essential job functions (See attached job description ☐):
   _____
   _____
   _____
   _____
   _____

To be completed by the EMPLOYEE:

1. Employee Name: _____
2. Name of family member: _____
3. Relationship of family member to employee: _____
4. If family member is employee's child, date of birth: _____
5. Date serious health condition began: _____
6. Probable duration of serious health condition: _____
7. Estimate of leave needed to provide care (including schedule if leave is needed on an intermittent and/or reduced work schedule):
   _____
   _____
   _____

_____ _____

Signature of Employee Date

To be completed by the HEALTH CARE PROVIDER:

1. Provider's Name: _____
2. Provider's Address: _____
3. Type of practice and/or medical specialty: _____

Note to Health Care Provider: DO NOT DISCLOSE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT.

4. Name of Patient: _____
5. Date medical condition or need for treatment commenced: _____
6. Probable duration of medical condition or need for treatment:_____
7. Does the patient's condition qualify as a "serious health condition" under the Family and Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA)? (See attached sheet for definition of "serious health condition.")

   ☐ Yes ☐ No

8. Does the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

   ☐ Yes ☐ No

9. After review of the employee's signed statement (See items 1 – 7 above) 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

10. Estimate the period of time care will be needed or during which the employee's presence would be beneficial:_____
11. If the employee has asked for intermittent leave and/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

12. If intermittent leave is necessary, 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): _____
13. If intermittent leave is necessary, please indicate the frequency of the employee's need for intermittent leave due to the serious health condition and the duration of such leaves (e.g., 1 episode every 3 months lasting 1-2 days):

    Frequency: _____ times per _____ week(s) _____ month(s)

    Duration: _____ hour(s) or _____ day(s) per episode

14. If the employee has asked for reduced schedule leave, is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition?

☐ Yes ☐ No

15. If a reduced schedule is necessary, please indicate the part-time or reduced work schedule the employee needs:

_____ hour(s) per day; _____ day(s) per week from _____ through _____

Signature of Employee: _____ Date: _____

Printed Name of Health Care Provider: _____ Date: _____

Signature of Health Care Provider: _____ Date: _____

"Serious Health Condition" as defined under FMLA / CFRA

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

1. Hospital Care
    a. 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. 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:
        i. Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provided, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
        ii. 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.
3. Pregnancy
    a. **Covered as a serious health condition under FMLA only**
    b. Includes incapacity due to pregnancy, or for prenatal care.
4. Chronic Conditions Requiring Treatment
    a. A chronic condition which:
        i. 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;
        ii. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
        iii. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
5. Permanent/Long-Term Conditions Requiring Supervision
    a. 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)
    a. 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).