

CERTIFICATION OF HEALTH CARE PROVIDER

for California Family Rights Act (CFRA) or Family and Medical Leave Act (FMLA)



Return to:
California State University, San Bernardino
HR - Benefits Department, Sierra Hall, Rm. 113
5500 University Parkway San Bernardino, CA 92407
Fax: (909) 537-7634

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 the Act, 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.

1. Employee Name: _____

2. Patient's Name (if other than employee): _____

Patient's Relationship to Employee: _____

If patient is employee's child, is patient either under 18 or an adult dependent child: _____ Yes _____ No

3. Date medical condition or need for treatment commenced [NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF THE PATIENT]:

4. Probable duration of medical condition or need for treatment: _____

5. Below is a description of what constitutes a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient's condition qualify as a serious health condition? _____ Yes _____ No

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 next question) _____ Yes _____ No

Is 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 questions only if the employee is asking for intermittent leave or a reduced work schedule:

Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee or family member? Yes No

If yes, please indicate the estimated 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:* ___ hours or ___ day(s) per episode

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 of the employee or family member? Yes No

If yes, please indicate the part-time or reduced work schedule the employee needs:

Frequency: ___ hour(s) per day; ___ days per week, from _____ through _____.

Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services? Yes No

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: ___ times per ___ week(s) ___ month(s) *Duration:* ___ hours or ___ day(s) per apt./treatment

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.
****TO BE 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 the employee 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:

Printed Name of Health Care Provider: _____

SIGNATURE OF HEALTH CARE PROVIDER

DATE

SIGNATURE OF EMPLOYEE

DATE