CITY AND COUNTY OF SAN FRANCISCO
Certification of Health Care Provider under the
Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA)
And Pregnancy Disability Leave (PDL)

FML 2

PLEASE GIVE THIS FORM TO YOUR HEALTH CARE PROVIDER AFTER COMPLETING SECTION I

Section I: TO BE COMPLETED BY THE EMPLOYEE

Employee's Name: _____ Classification: _____

Department: _____

Personnel Official's Name: _____ Telephone Number: _____

Patient's Name (if different from employee): _____ Relationship: _____

Section II: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Certification of Health Care Provider of a Serious Health Condition
(Family and Medical Leave Act (FMLA) of 1993, California Family Rights Act (CFRA)
and Pregnancy Disability Leave (PDL).)

Dear Health Care Provider:

The above-named employee has requested a leave of absence or intermittent leave for his/her health condition, or the condition of a family member, which may qualify as a protected leave under the FMLA, CFRA and/or PDL. This medical certification form will provide us with information needed to determine if the employee' is eligible under the FMLA, CFRA and/or PDL. Section II must be completed and returned to the department by the employee or your office. **In all cases, it is the employee's responsibility to ensure that sufficient medical certification is provided to the department.**

INSTRUCTIONS

The information sought on this form relates only to the condition for which the employee is taking leave. For the purposes of this form, "incapacity" is defined as the inability to work, attend school, or perform other regular daily activities due to the serious health condition itself, treatment of the serious health condition, or recovery from the condition. "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. A regimen of continuing 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 of treatment does not include taking over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or other similar activities that can be initiated without a visit to a health care provider.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. To comply with GINA, we are asking that you **not** provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or individual's family member sought or received genetic services, and genetic information of a fetus to be carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SERIOUS HEALTH CONDITION

1. The definitions below describe what is meant by a "serious health condition" under the FMLA and/or CFRA. Does the patient's condition(s) qualify under any of the categories described? If so, please check the appropriate category.

☐ **CATEGORY 1: In-Patient Care**

Any period of incapacity or treatment connected with 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.

☐ **CATEGORY 2: Absence Plus Treatment**

A period of incapacity of more than three (3) consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, which also involves:

1) Treatment two (2) or more times, within 30 days of the first day of incapacity, by a health care provider, by a nurse 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
2) Treatment by a health care provider on at least one (1) occasion, which results in a regimen of continuing treatment under the supervision of the health care provider, e.g., prescribed medication.

☐ **CATEGORY 3: Pregnancy or Prenatal Care**

Any period of incapacity due to pregnancy, or for prenatal care. Expected delivery date: _____

☐ **CATEGORY 4: Chronic Conditions**

Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:

1) 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;
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.

☐ **CATEGORY 5: Permanent or 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.

☐ **CATEGORY 6: Conditions Requiring Multiple Treatments**

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, for:

1) Restorative surgery after an accident or other injury; or
2) A condition that would likely result in a period of incapacity of more than three (3) consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

☐ **NO CATEGORY APPLIES**

Employee's Name: _____ Patient's Name: _____

SUPPORTING MEDICAL FACTS

1. State the approximate date the condition commenced [**NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE PATIENT'S WRITTEN CONSENT**]:

   _____

2. State the probable duration of the condition or need for treatment:

   _____

3. State the probable duration of the employee's/patient's incapacity, if different from the duration of the condition.

   _____

IF THE CERTIFICATION IS FOR THE <u>EMPLOYEE'S SERIOUS HEALTH</u> CONDITION, ANSWER THE FOLLOWING:

4. Is employee able to perform work of any kind? (If no, proceed to question 5) ☐ YES ☐ NO

   a. If the employee is able to perform some work, is employee unable to perform any one or more of the essential functions of employee's position due to the serious health condition? (Answer after discussing essential job functions with employee.) ☐ YES ☐ NO

   b. If yes, please specify the work restrictions that preclude the employee from performing one of more of his or her essential job functions:

      _____

      _____

IF THE EMPLOYEE IS ASKING FOR <u>INTERMITTENT LEAVE,</u> OR A <u>REDUCED WORK SCHEDULE,</u> ANSWER THE FOLLOWING AND RESPOND TO SECTION a, b OR c:

5. Is it medically necessary for the employee to be off work on an intermittent basis due to the employee's serious health condition? ☐ YES ☐ NO

   a. If yes, estimate the frequency of flare-ups, treatments or care and the duration of related incapacity or absence that the patient may have and for what period of time (e.g., "*1 time per 3 months, lasting 1-2 days, from Jan 1 through Jun 30, 2012*" OR "*PT 2 x wk, for ½ hour for 6 wks (May 17 through Jun 25, 2010)*"):

   Frequency: _____ times per _____week(2) or _____month or _____year

   How long is the employee incapacitated by each flare-up?

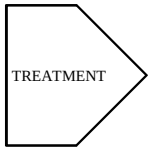
   Duration: _____hour(s) or _____ day(s) per episode

   Flare-ups may occur from (date): _____through:_____

   Comments:_____

   _____

   b. Scheduled Treatments: _____ times per _____week or _____month or _____year

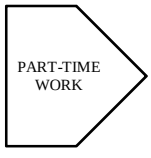


   Duration: _____hour(s) or _____ day(s) per appointment/treatment

   Treatments can be scheduled during non-work hours ☐ YES ☐ NO

   Duration from (date): _____through:_____

   c. Is it medically necessary for the employee to work a reduced schedule due to the serious health condition of the employee? ☐ YES ☐ NO



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

   Employee can work _____hour(s) per day for _____days per week, through _____

Employee's Name: _____ Patient's Name: _____

IF THE EMPLOYEE IS <u>NOT</u> THE PATIENT, AND THE CERTIFICATION IS FOR THE EMPLOYEE'S FAMILY MEMBER WHO NEEDS CARE, ANSWER THE FOLLOWING AND RESPOND TO SECTION a, b OR c:

6. 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 attached Request for Leave form), 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

7. Estimate the period of time care will be needed or during which the employee's presence would be beneficial:

a. Frequency: _____ times per _____week(s) or _____month(s) or _____year(s)

INTERMITTENT CARE

How long is the employee required to care for the family member on each occasion?

Duration: _____hours or _____ day(s) per incident

Intermittent leave required from (date): _____through:_____

Comments:_____

_____

_____

b. Scheduled Treatments: _____ times per _____week(s) or _____month(s) or _____year(s)

ACCOMPANY TO TREATMENT

Duration: _____hours or _____ day(s) per appointment/treatment

Treatments can be scheduled during non-work hours ☐ YES ☐ NO

Duration from (date): _____through:_____

c. Is it medically necessary for the employee to work a reduced schedule due to the serious health condition of the employee's family member? ☐ YES ☐ NO

PART-TIME WORK

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

Employee can work _____hour(s) per day for _____days per week, through _____

_____ _____
(Signature of Health Care Provider) (Date)

_____ _____
(Print Name of Health Care Provider) (License No.)

_____ _____
(Address) (Fax number)

_____ _____
(City) (State) (Zip Code) (Telephone number)