SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

CERTIFICATION OF HEALTH CARE PROVIDER

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

CIVIL RIGHTS DEPARTMENT · STATE OF CALIFORNIA

***This form is for Leave to care for Family. If Leave is for Self, use the WH380 form.**

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.

1. Employee Name: _____

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

   Is patient the employee's family member (i.e., child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, domestic partner, or designated person)?

   Note: "child" includes a biological, adopted, foster child, a stepchild, a legal ward, a child of the employee's domestic partner, and a person to whom the employee stands in loco parentis. "Parent" includes a biological, foster, or adoptive parent, a parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child. A biological or legal relationship is not necessary for a person to have stood in loco parentis to the employee as a child. "Designated person" means any individual related by blood or whose association with the employee is the equivalent of a family relationship.

   ◯ 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**

SERIOUS HEALTH CONDITION

"Serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, domestic partner, or designated person of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

HOSPITAL CARE

Inpatient care 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. A person is considered an "inpatient" when a heath care facility formally admits the person to the facility with the expectation that the person will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

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:

1. 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
2. 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.

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.

CHRONIC CONDITIONS REQUIRING TREATMENT

A chronic condition, which:

1. Requires periodic visits for treatment by a health care provider, or by a nurse of 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.).

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.

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 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), or kidney disease (dialysis).