FMLA/CFRA MED-CERT

Certification of Health Care Provider

(Family and Medical Leave Act of 1993)

U. S. Department of Labor
Employment Standards Administration
Wage and Hour Division

1. Employee's Name	2. Patient's Name (if different from employee)

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ or None of the Above _____

4. a. State the approximate **date** the condition commenced, and the probable **duration** of the condition (and also the probable duration of the patient's present **incapacity** if different):

b. Will it be necessary for the employee to work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 5 below)? _____

If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]:

5. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments:

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent or part-time** basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment, if known, and period required for recovery, if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

c. **If a regimen of continuing treatment** by the patient is required under your supervision, 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.

[1] Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

[2] **"Incapacity"** for purposes of FMLA is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

6. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition, is the **employee unable to perform work of any kind**?

   _____

   b. If able to perform some work, is the **employee unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? _____ If yes, please list the essential functions the employee is unable to perform:

   c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment?**

   _____

7. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation? _____

   b. If no, **would** the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? _____

   c. If the **patient** will need care only **intermittently** or on a part-time basis, please indicate the probable duration of this need: _____

_____ _____
(Signature of Health Care Provider) (Type of Practice)

_____ _____
(Address) (Telephone number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____ _____
(Employee Signature) (Date)

A **"Serious Health Condition"** 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[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves

(1) **Treatment[3] 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[4]** under the supervision of the health care provider.

3. Pregnancy

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

4. Chronic Conditions Requiring Treatments

A chronic condition 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[2] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

A period of **incapacity[2]** 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 continuous 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 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[2] 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).

---

[3] 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.

[4] 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 the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bedrest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

DEPARTMENT OF GENERAL SERVICES

Notice-Request Family and Medical Leave Act/California Family Rights Act (FMLA/CFRA) Leave

Attendance Clerk Route completed form to your Personnel Transaction Specialist

Notice-Supervisor complete lines 1,3,4,5, and 6	Request-Employee complete lines 2,4,5, and 6

1. Supervisor notice employee of designation of FMLA/CFRA LEAVE
   Date _____
2. Employee request FMLA/CFRA LEAVE
   Date_____
3. Supervisor response to employee request
   Date_____
4. Employee Name_____
5. Employee Position Number_____
6. Employee Social Security Number_____providing this number is voluntary in accordance with the Privacy Act of 1974 (PS93-579)

THE DEPARTMENT ALLOWS ELIGIBLE EMPLOYEES TO TAKE UP TO TWELVE (12) WORKWEEKS OF PAID/UNPAID FMLA/CFRA LEAVE DUE TO:
Notice-Supervisor complete, Request-Employee complete

_____The birth of the employee's child, or the placement of a child with the employee for adoption or foster care;
_____A serious health condition that makes employee unable to perform the essential functions of his or her job;
A serious health condition affecting the employee's
_____spouse,
_____child,
_____parent, for which the employee is needed to provide care.

Employee Eligibility Supervisor complete

Employee is eligible, Notice-Request-for FMLA/CFRA leave is provisionally granted _____
Employee is not eligible, Request for FMLA/CFRA leave is denied_____
Reason for denial
_____

_____

LEAVE REQUEST DATES Notice-Supervisor complete, Request-Employee complete

_____FMLA/CFRA leave beginning date
_____FMLA/CFRA leave ending date
_____FMLA/CFRA incremental or reduced schedule
_____Total unpaid FMLA/CFRA leave requested
_____Total paid FMLA/CFRA leave requested

PAYMENT OF BENEFITS DURING UNPAID FMLA/CFRA LEAVE
Notice-Supervisor complete, Request-Employee complete

_____Health Plan
_____Dental Plan
_____Vision Plan
_____No continuation of benefits is requested
_____I understand that by electing to continue these benefits during my unpaid FMLA/CFRA leave, I am assuming responsibility for the agency collection accounts receivable that will be established to pay for any portion of premium payments normally paid by me to maintain such coverage. I further acknowledge that should I fail to return to work or return to work for less than thirty (30) days, following my FMLA/CFRA leave, for a reason other than (1) the continuation, recurrence, or the onset of a serious health condition, affecting either myself or eligible family member, which would otherwise entitle me to FMLA/CFRA leave; (2) retirement, (3) or other circumstances beyond my control, I may be required to reimburse the Department for its share of health insurance premiums paid during my FMLA/CFRA leave.

WHEN EMPLOYEES WILL BE REQUIRED TO PROVIDE MEDICAL INFORMATION
Supervisor check applicable line on items 1-5

1. The Department will allow eligible employees who have a qualified FMLA/CFRA reason to use up to twelve (12) workweeks of paid accrued leave, e.g. annual, personal leave, sick leave and vacation, under the guidelines of the FMLA/CFRA. Until such certification is provided, the paid leave will be provisionally counted as FMLA/CFRA leave. Employees must provide medical certification (*FMLA*/*CFRA Med-Cert)* from their health provider within fifteen (15) days of the leave request. Failure to provide this certification within fifteen (15) days of the leave request may result in the employee being unable to use accrued leave under the guidelines of the FMLA/CFRA.
   Must provide _____Non-applicable_____
2. The Department will allow eligible employees who have a qualified FMLA/CFRA reason, to use up to twelve (12) workweeks of unpaid job-protected leave with employer-paid health, dental, and vision benefits. Employees must provide medical certification (*FMLA*/*CFRA Med-Cert*) from their health care provider within fifteen days. Until such certification is provided, the unpaid leave will be provisionally counted as FMLA/CFRA leave. Failure to provide this certification within fifteen (15) days of the leave request may result in denial of the FMLA/CFRA leave.
   Must provide _____Non-applicable_____

3. The Department may, at its expense, obtain a second medical opinion of the employee's medical certification. If the first and second opinions differ, the Department may, at its expense, obtain a third opinion from a health care provider jointly selected by the employee and employer. The third opinion is binding. Upon request of the employee, the Department will furnish the employee with copies of any additional medical opinions. The Department will reimburse employees for out-of-pocket travel expenses incurred to obtain second or third opinions.
   Must provide _____Non-applicable_____
4. If an employee requests additional time beyond that which was originally estimated for the employee's FMLA/CFRA leave, re-certification may be required. Re-certification may also be required if the Department receives information that causes it to question the stated reason for the absence. Failure to submit required re-certification may result in termination of the leave. No second or third opinion will be allowed on re-certifications.
   Must provide _____Non-applicable_____
5. When the employee returns to work at the conclusion of FMLA/CFRA leave taken for their own serious illness, they will be required to furnish their supervisor with a note from their health care provider releasing the employee to work. No second or third opinion will be allowed on releases to resume work. However, a health care provider employed by the Department may contact the employee's health care provider, with the employee's permission, for purposes of clarification of the employee's fitness to return to work. The employee's return to work will not be delayed by this contact.
   Must provide _____Non-applicable_____

Periodic Reporting of Condition Supervisor check applicable line

Employees on a FMLA/CFRA leave that does not have a stated amount of time, may be asked to periodically, no more often than every thirty (30) days, report on their status and intent to return to work.
Must provide _____Non-applicable_____

_____ _____

Employee's Signature Date Supervisor's Signature Date

(Employee's signature not required)

Your Rights
Under The
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Reasons For Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts By Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA:
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
June 1993

U.S. GOVERNMENT PRINTING OFFICE:1996 171-169