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HEALTH CARE PROVIDER CERTIFICATION FOR EMPLOYEE OR FAMILY MEMBER

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.

INSTRUCTIONS: Section II MEDICAL FACTS must be completed by the employee's Health Care Provider for Employee to submit to the Leave Program Manager for Family Medical Leave (FML) eligibility and determination. Complete and sufficient information is required on page one (1) and page two (2) to evaluate an employee's leave of absence request. Failure to submit requested information will result in denial of leave request. Unapproved leaves are subject to department disciplinary action.

Section I. For completion by EMPLOYEE where applicable

If request for medical leave is for qualified family member, employee must complete statement of family member care.

Employee Name: _____ Patient: _____

Patient's relationship to employee: _____

* **EMPLOYEE STATEMENT OF FAMILY MEMBER CARE – If medical leave is for self then statement is NOT required.**

Provide a description of the care you will provide for your seriously-ill family member. (For assistance, review the following questions asked of the health care provider (SECTION II) to support your statement.)

Employee Signature: _____ Date: _____

Section II. For completion by HEALTH CARE PROVIDER ONLY

MEDICAL FACTS – Do not disclose underlying diagnosis without consent of the patient.

The following is a list of serious health conditions. For a description of what constitutes a "serious health condition" according to state law see page three (3).

- Hospital care Absence plus treatment
- Pregnancy
- Chronic conditions requiring treatment
- Permanent/Long-term conditions requiring supervision
- Multiple treatments (non-chronic conditions)

1. Does the patient's condition qualify as a serious health condition? ☐ Yes ☐ No* – see following instructions.

* If **no**, do not proceed with questions. Complete Health Care Provider Information on bottom of page and provide to the employee to submit to the Leave Program Manager.

2. When is medical leave START date: (date medical condition or need for treatment commenced): _____

3. When is medical leave END date: (probable duration of medical condition or need for treatment): _____

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If patient is EMPLOYEE please answer questions.	If patient is FAMILY MEMBER please answer questions.
4A. Can your patient perform their essential job duties if were not provided medical leave? ☐ Yes* ☐ No **5A.** If no, please describe which essential job duties your patient would not be able to perform: * If yes, your patient does not qualify for medical leave and continue to perform their essential job duties.	**4B.** Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ☐ Yes ☐ No **5B.** Estimate the period of time the patient will need care during which the employee's presence would be beneficial to participate in care for the patient:

Please answer the following questions only **if** the employee is asking for intermittent leave or a reduced work schedule.

6. *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 – answer 6a ☐ No – not applicable

6a. If yes, please specify the estimated frequency of the employee's need for intermittent leave and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days).

Frequency (e.g. how often): _____ Duration (e.g. how long per episode/flare up): _____

7. *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 – answer 7a ☐ No – not applicable

7a. If yes, please specify the part-time or reduced work schedule hours that is recommended:

Frequency (e.g. hours per day or week): _____ Duration (e.g. length of time): _____

8. *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 – answer 8a ☐ No – not applicable

8a. 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 (e.g. how often in day/week/month) _____ Duration (e.g. length of time): _____

Complete and sufficient Health Care Provider Information is required for valid certification.

HEALTH CARE PROVIDER INFORMATION

Name: _____ Specialty: _____ License No. _____

Medical Facility/Address: _____

Tel. _____ Fax: _____ Signature: _____ Date: _____

I hereby certify that the information provided is true and accurate to the best of my knowledge.

Completed forms may be faxed to (408) 924-4358 or emailed to leaves@sjsu.edu with subject "Attention: Leave Program Manager"

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).