FAMILY AND MEDICAL LEAVE CERTIFICATION

EMPLOYEE: PLEASE COMPLETE TOP PORTION AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER.

Employee:	
Patient (if other than employee):	Relation to employee:
Begin date of requested leave:	End date of requested leave:
Supervisor:	Telephone:

(optional)

If leave is for my own serious health condition, I authorize my health care provider to provide my diagnosis. ☐ Yes ☐ No

Signature: Date:

HEALTH CARE PROVIDER: PLEASE COMPLETE THIS FORM AND RETURN TO EMPLOYER LISTED ON REVERSE SIDE.

IF LEAVE IS BECAUSE OF EMPLOYEE'S SERIOUS HEALTH CONDITION

Does this employee have a serious health condition? (See reverse side for definition) **If authorized**, what is employee's diagnosis?	☐ Yes ☐ No
When did the serious health condition begin?	
Please review the attached job description. Is this employee able to perform the functions of his or her job?	☐ Yes ☐ No
If intermittent leave or a reduced work schedule is being considered, is it medically necessary? If so, please describe the recommended schedule.	☐ Yes ☐ No
What is the anticipated return to work date?	

IF LEAVE IS BECAUSE OF THE SERIOUS HEALTH CONDITION OF EMPLOYEE'S FAMILY MEMBER

Does employee's family member have a serious health condition? (See reverse side for definition)	☐ Yes ☐ No
When did the serious health condition begin?	
Is the employee's presence necessary or would it be beneficial to the patient? (This may include psychological comfort and/or arranging for third-party care for the family member.)	☐ Yes ☐ No
If intermittent leave or a reduced work schedule is being considered, is it medically necessary? If so, please describe the recommended schedule.	☐ Yes ☐ No
What is the anticipated return to work date?	

Name of Health Care Provider:	
Specialty:	
Address of Health Care Provider:	
Signature of Health Care Provider _____ Date _____	Place address stamp here.

RETAIN: 3 YEARS 01/00

Dear Health Care Provider:

Our employee has requested leave under the provisions of Federal and/or California family and medical leave statutes for:

- his or her own serious health condition; or
- for the purpose of caring for your patient (who is a parent, child, or spouse of our employee).

In order for the University to determine whether this leave qualifies for family and medical leave under Federal and/or State law, please complete the brief Health Care Provider section on the reverse side of this letter and return by mail to:

Do not release employee's diagnosis unless authorized by employee (see "Employee Section" of this form for authorization).

If you have any questions, please phone the supervisor listed on the reverse side. Thank you for your assistance.

A serious health condition is

any illness, injury, impairment or physical or mental condition that involves:

- any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or
- continuing treatment by a health care provider for one or more of the following:
  - any period of incapacity for more than three consecutive calendar days that also involves treatment two or more times or treatment on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.
  - any period of incapacity due to pregnancy, for prenatal care.
  - any period of incapacity due to a chronic serious health condition that:
    - requires periodic visits for treatment;
    - continues over an extended period of time; and
    - may cause episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, etc.)
- any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease).
- Any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition such as cancer or kidney disease.

A serious health condition is not

- allergies, stress, or substance abuse unless inpatient hospital care is required, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health condition; or
- voluntary treatment or surgery unless inpatient hospital care is required.

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, dentist, clinical psychologist, optometrist, nurse practitioner, nurse-midwife who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.