CAL POLY
SAN LUIS OBISPO

Certification of Health Care Provider

Employee's Request for Family and Medical Leave

This Form Is To be completed by the Health Care Provider:

Please provide the requested information below in relation **only** to the condition for which the employee is taking leave.

NOTE-THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF THE PATIENT.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, 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 an individual's family member sought or received genetic services, and genetic information of a fetus 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.

1. Employee's Name:	**2. Patient's Name (if other than employee):**

3. On the reverse side is a description of what is meant by a "serious health condition" under both the federal and state family and medical leave laws. Does the patient's condition qualify under any of the categories described? ☐ No ☐ Yes If yes, please check the appropriate category below:

_____ Inpatient care _____ Chronic condition requiring treatments _____ Permanent/longterm condition requiring supervision
_____ Pregnancy _____ Absence plus treatment _____ Multiple treatments (non-chronic condition)

4. Date medical condition or need for treatment commenced (mm/dd/yyyy):	**5. Probable duration of medical condition or need for treatment (mm/dd/yyyy):**

6. If the certification is for the serious health condition of the employee, please answer the following:

a. ☐ YES ☐ NO Is employee able to perform work of any kind? (If "No" skip next question)

b. ☐ YES ☐ NO Is employee **unable** to perform any one or more of the essential functions outlined in the provided employee's certified position description (if position description has been omitted, obtain a statement of responsibilities by discussing with employee)?. Identify any medically determined work restrictions below: _____

_____

_____

7. Does the employee need intermittent leave or a reduced work schedule:

a. ☐ YES ☐ NO Is it medically necessary for the employee to be off work on an intermittent basis or work less than the employee's normal work schedule in order to deal with a serious health condition of the employee or family member?

If **YES**, please clearly detail the number of hours/days per week/month medically necessary for the employee to be off work for doctor's appointments, medical treatments , or other health provider services: _____

_____

8. If the certification is for the care of the *employee's family member*, please answer the following:

a. ☐ YES ☐ NO Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

b. ☐ YES ☐ NO After review of the employee's certified position description or obtained statement, 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.)

9. Please clearly estimate the period of time each day/week care is needed during which employee's presence would be beneficial: _____

_____

Name of Health Care Provider (please print):	**Signature of Health Care Provider:**
Type of Practice:	**Date:**
Address:	**Telephone Number: ( )**

Please complete and return to: Human Resources, Cal Poly State University, Attention Shelly Giesmann Disability Programs Coordinator, Building 001-110, San Luis Obispo, CA 93407 PH: (805) 756-5395 FX: (805) 756-5483

DEFINITION (AND CATEGORIES) OF SERIOUS HEALTH CONDITION

Family and Medical Leave Act of 1993

Definition of Serious Health Condition: 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 [1] or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**

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

   a) Treatment[2] 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*

   b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[3] under the supervision of the health care provider.

3. **Pregnancy**

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

4. **Chronic Condition Requiring Treatments**

   A chronic condition which:

   a) 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.

   b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   c) May cause episodic rather than a continuing period of incapacity[1] (e.g. asthma, diabetes, epilepsy, etc.)

5. **Permanent/Long-term Conditions Requiring Supervision**

   A period of incapacity[1] which is permanent or long-term due to a condition for which treatment may 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.

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 order of, or on referral by, a health care provider, either:

   a) For restorative surgery after an accident or other injury, or

   b) For a condition that would likely result in a period of incapacity[1] of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

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[1]"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.

[2]Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition
Treatment does not include routine physical examination, eye examinations, or dental examinations.

[3]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; bed-rest, drinking fluid, exercise and other similar activities that can be initiated without a visit to a health care provider.