CALIFORNIA STATE UNIVERSITY, LONG BEACH

Fair Employment & Housing Commission
Certification of Health Care Provider

Family and Medical Leave Act (FMLA)
California Family Rights Act (CFRA)

1. Employee's Name:

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

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IF PATIENT IS SOMEONE OTHER THAN THE EMPLOYEE, EMPLOYEE MUST COMPLETE ITEM 10 ON PAGE 4 BEFORE PROVIDING CERTIFICATION OF HEALTH CARE PROVIDER FORM TO THE HEALTH CARE PROVIDER.

3. Date medical condition or need for treatment commenced:

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4. Probable duration of medical condition or need for treatment:

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NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT. IN ADDITION, THE GENETIC INFORMATION NON-DISCRIMINATION ACT OF 2008 (GINA) PROHIBITS EMPLOYERS AND OTHER ENTITIES COVERED BY GINA TITLE II FROM REQUESTING OR REQUIRING GENETIC INFORMATION OF AN 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 INDIVIDUALS' OR FAMILY MEMBER'S GENETIC TEST, 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.

1250 Bellflower Boulevard, Long Beach, CA 90840

5. Does the patient’s condition qualify under any of the categories of a “serious health condition” described below? If so, please select the appropriate category.

A. Hospital Care

Inpatient (i.e., an overnight stay) 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.

B. Absence Plus Treatment

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, 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 order of, or 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.

C. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.
(NOTE: AN EMPLOYEE’S OWN INCAPACITY DUE TO PREGNANCY IS COVERED AS A SERIOUS HEALTH CONDITION UNDER FMLA ONLY)

D. Chronic Conditions Requiring Treatment

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 (e.g. asthma, diabetes, epilepsy, etc.).

E. 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 terminal stages of a disease.

F. 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), kidney disease (dialysis).

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

   A. Is the employee able to perform work of any kind? (If "No", skip question **B**) Yes No

   B. Is the employee unable to perform any one or more of the essential functions of the 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:

   A. Does/will the patient require assistance for basic medical hygiene, nutritional needs, safety or transportation? Yes No

   B. After review of the employee's signed statement (item 10 below), does the condition warrant the participation of the employee? Yes No

8. (For the care of employee's family member) What is the estimated period of time that the patient will require care during which the employee's presence would be beneficial?

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

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

   B. If yes, 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.

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ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY LEAVE IN THE EVENT THAT THE PATIENT IS SOMEONE OTHER THAN THE EMPLOYEE.

10. When family care leave is needed to care for a seriously-ill family member, the employee shall state the care he or she 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.

    Employee: Please indicate in the space below the care that you will provide and the estimated time period during which this care will be provided.

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____
Health Care Provider Name

____ ___________________________
Health Care Provider Address Phone Number

____ ___________________________
Signature of Health Care Provider Date

____ ___________________________
Signature of Employee Date

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