# Certification of Health Care Provider – FMLA/CFRA/PDL
# Employee or Family Member Serious Health Condition
## CLASSIFIED EMPLOYEES

**SECTION I: For Completion by the EMPLOYEE**

Please read and complete Section I before presenting this form to your medical provider. FMLA, CFRA, and PDL state that an employer has the authority to require an employee to submit a timely, complete and sufficient medical certification to support a request for FMLA, CFRA, or PDL leave. Submittal of the medical certification is required by PVSD in order to obtain and/or retain leave protections. **Failure to provide a complete and sufficient medical certification may result in the denial of a request for protected leave.** Employees have at least 15 calendar days to return this form.

The Genetic Information Nondiscrimination Act of 2008, Title II (GINA) prohibits employers and other entities covered by GINA, from requesting genetic information of an individual or family member, except as specifically allowed by this law. To comply with GINA, do not provide any genetic information when responding to this request for medical information.

Employee's full name: ______________________________

Patient's name if other than employee: ______________________________

Patient's relationship to employee: ______________________________

Employee's Signature: ______________________________ Date: ______________

**Section II: For Completion by the HEALTH CARE PROVIDER**

Please complete Section II of this document. Please provide complete answers to all applicable questions below. Several questions seek a response regarding the frequency or duration of a condition and/or treatment. Your answer should be your BEST ESTIMATE based upon your examination of the patient and your prognosis. Please be as specific as possible, noting that terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to grant leave protections. Limit your responses to address only the condition for which the employee is seeking a protected leave.

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: ______________________________

   Probable duration of condition or need for treatment: ______________________________

2. Check definitions of serious health conditions below (A - F) that apply. (Detailed list attached)

   ☐ A. In-patient care in a hospital, hospice, or residential medical care facility
   If yes, provide date(s) of admission: ______________________________
   ☐ B. Serious incapacity of more than 3 consecutive calendar days + 2 treatments
   ☐ C. Incapacity causing absence due to pregnancy or prenatal care
   If yes, expected delivery date: ______________________________
   ☐ D. Serious chronic condition causing incapacity and requiring treatments
   ☐ E. Serious permanent condition or serious long-term condition
   ☐ F. Multiple treatments for serious health condition

3. Please review the employee's essential functions and/or a job description, or answer these questions based upon the employee's own description of his/ her job functions.

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

   A. Is the employee unable to perform any of his/her job functions due to the condition?
      Yes ☐ No ☐

      If yes, identify the job functions the employee is unable to perform:

      ____________________________________________

      ____________________________________________

      ____________________________________________

   B. If the certification is for the care of the employee's family member, please answer the following:
      Does (or will) the patient require assistance for basic medical hygiene, nutritional needs, safety, transportation, psychological comfort and/or arranging for third-party care for the family member? Yes ☐ No ☐

**PART B: AMOUNT OF LEAVE NEEDED**

1. **Single Continuous Period of Time:** Is it medically necessary for the employee to be off work due to serious health condition of the employee or family member? Yes ☐ No ☐

   If yes, estimate the beginning and ending dates for the period of incapacity from:

   ___________________________ through ____________________________

2. **Reduced Schedule Leave:** Is it medically necessary for the employee to work less than the employee's normal work schedule due to serious health condition of the employee or family member? Yes ☐ No ☐

   If yes, indicate the part-time or reduced work schedule the employee needs:

   _____Hours per day; _____Days per week; from ______________ through _______________

   NOTES: ____________________________________________

3. **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? Yes ☐ No ☐

   If yes, estimate treatment frequency and treatment duration (including recovery period)

   Frequency: _____ times per _____ week(s) or _____ month(s)

   Duration: _____ hour(s) or _____ day(s) per appointment/treatment

   NOTES: ____________________________________________

4. **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 ☐ No ☐

   If yes, based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may need (e.g., 1 episode every 3 months lasting 1 -2 days):

   Frequency: ______ times per week(s) or ______ month(s)

   Duration: ______ hour(s) or ______ day(s) per episode

   NOTES: ______________________________________________

**Health Care Provider Verification**

Please provide the following information pertaining to your practice:

Your Name ______________________________________________

Address ______________________________________________

Zip Code ______________________ Telephone ______________________

Endorse the following statement: "I certify that I am the treating health care provider for the above-named patient who is under my professional care. All of this information is true and correct to the best of my knowledge."

Signature: ______________________________ Date: ______________

**Please return this form to the employee as soon as possible or send to:**

Pleasant Valley School District
Classified Human Resources Department
600 Temple Avenue
Camarillo, CA 93010
(805) 445-8663; **Confidential FAX: (805) 445-8612**

## Thank you!! We appreciate your time!

## Definitions of Serious Health Conditions

**A. 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 health care facility formally admits him or her to the facility with the expectation that he or she 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.

**B. Absence Plus Treatment**

a. 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:

    i. 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

    ii. 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

**D. Chronic Conditions Requiring Treatment**

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 (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 the terminal stages of a disease.

**F. Multiple Treatments (Non-Chronic Conditions)**

A 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 (3) 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).