



Certification of Health Care Provider for Employee California State University Family Medical Leave (CSU FML)*

Employee Name: _____

SECTION I: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS: Your patient has requested leave under the CSU FML. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. **Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine CSU FML coverage.** Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

NOTE: The health care provider is not to disclose the underlying diagnosis without the consent of the patient. In addition, 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.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

The list below describes what is meant by a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following.

Please check the appropriate category

Hospital Care

Inpatient care (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.

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:

- 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
- 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:

- 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;
- Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- 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), kidney disease (dialysis).

1. Approximate date condition commenced: _____

2. Probable duration of condition: _____

3. Answer after reviewing statement from employer of employee's essential job functions, or, if none provided, after discussion with employee.)

Is the employee unable to perform **any** of his or her job functions during the duration of the condition? Yes No

If **YES**, describe which functions the employee is unable to perform: _____

4. Does the Employee need to be off of work for a continuous period of time? Yes No

If **YES**, estimate the beginning and ending dates: _____

5. Is it medically necessary for the employee to be off of work intermittently because of episodic flare ups and/or to attend follow up treatments? 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 have over the next 6 months (e.g., 1 episode per 3 months for 1-2 days):

Frequency: _____ times per _____ week(s) **OR** _____ month(s)

Duration: _____ hours **OR** _____ day(s) per episode

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

6. Is it medically necessary that the employee work on a part-time or on a reduced schedule because of the employee's medical condition? Yes No

If **YES**, estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

If **YES**, estimate the **part-time or reduced** work schedule the employee needs, if any:
_____ Hour (s) per day; _____ days per week from _____ through _____

Signature of Employee

Date

Signature of Health Care Provider

Date

The form is to be returned to Human Resources, MSR320 for participation; faxes are also accepted to (209) 664-7182. Questions may be directed to the Leaves Administrator at (209) 664-6921.

*CSU FML incorporates both the Federal Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) leave entitlements which in most cases run concurrently.