FMLA Definition of Serious Health Condition

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Inpatient 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.

2. **Incapacity of More Than 3 Consecutive Days Plus Continuing Treatment by a Health Care Provider**
   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:

   (a) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provided, 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 under the supervision of the health care provider (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). Note: This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

3. **Pregnancy**
   A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.
   (Covered under the FMLA only)

4. **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.).

5. **Permanent/Long-Term Conditions Requiring Supervision**
   A period of incapacity that 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.

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 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).

9. If no, is the employee unable to perform one or more of the essential functions of her position without undue risk to herself, to others, or the successful completion of her pregnancy? ____ No _____ Yes

Effective Date: _____ Ending Date (Estimate): _____

Please specify specific essential functions that employee may not perform within the beginning and ending date

_____

ADDITIONAL INFORMATION:

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Signature of Health Care Provider **Date**

I certify that I am the physician providing care for the patient identified in this document and that the statements made by me are true and correct to the best of my knowledge.

Reference: Government Code sections 12935, subd. (a), 12940, 12945; FMLA, 29 U.S.C. §2601, et seq. and FMLA regulations 29 C.F.R §825

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.

If no, is the employee unable to perform one or more of the essential functions of her position listed on the attached job description without undue risk to herself, to others, or the successful completion of her pregnancy?
____ No ____ Yes

3. Is it medically advisable that the employee be temporarily transferred to another position due to a health condition related to her pregnancy or childbirth? ____ No _____ Yes

If yes, what is the date the transfer became/will become medically advisable? _____

What is the probable duration of the period(s) of need for a transfer? _____
_____

4. Does the employee need an accommodation (other than a transfer) to be able to perform the functions of her position without undue risk to herself, others, or the successful completion of her pregnancy?
_____ No _____ Yes

Please describe your recommended accommodation(s): _____
_____
_____
_____
_____

5. Will employee require time off for medical appointments? ____ No _____ Yes

Per Week Per Month Hours
Number of anticipated doctor visits _____ or _____ Number of hours per visits _____

6. Is it medically advisable for the employee to work a reduced schedule? ____ No _____ Yes

If the employee needs a reduced schedule, estimate the part-time or reduced work schedule the employee needs:

Employee should work no more than: _____ Hour(s) per day _____ Days per week

Beginning Date: _____ Ending Date: _____

7. Is it medically advisable for the employee to take leave on an intermittent basis for periods of incapacity or medical treatment? ____ No _____ Yes

   If so estimate the frequency of the need for intermittent leave and the duration of incapacity to perform work duties:

   Number of anticipated flare-ups _____ per ☐ week or ☐ month

   Duration of flare-ups _____ per ☐ hours or ☐ days

8. Is employee unable to perform work of any kind without undue risk to herself, others or the successful completion of her pregnancy? ____ No _____ Yes

   Effective Date: _____ Ending Date (Estimate): _____

Certification of Health Care Provider for Employee's Pregnancy Disability

California Disability Leave Law ("PDL") and Federal Family & Medical Leave Act (FMLA)

INSTRUCTIONS to EMPLOYEE: You are required to submit a timely, complete, and sufficient medical certification to support your request for PDL leave due to your pregnancy, childbirth, or related medical condition. Providing this completed form is required to obtain (or retain) the benefit of PDL protections for your leave. Failure to provide a complete and sufficient medical certification to your employer may result in a delay or denial of your leave request.

You should return this completed form as soon as practicable, but no later than _____**20**____. You may return the form in person, by mail, or by fax. The fax number is _____. You should include a fax cover sheet marked "CONFIDENTIAL" and address your fax to "ATTENTION: _____."

SECTION I – To be completed by EMPLOYER

Employee's name:

_____

Name and contact information of District's representative:

_____

Employee's job title: _____

Employee's regular work schedule: _____

Check if job description is attached: _____

SECTION II – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient (our employee) has requested leave under the PDL due to a health condition related to her pregnancy or childbirth. Please answer, fully and completely, all applicable parts. Your answers should be based upon your medical knowledge, experience, and examination of the employee. Be sure to sign and date the form on page 2.

NOTE: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSES WITHOUT THE PATIENT'S CONSENT.

Provider's name and business address: _____

_____

Type of practice: _____

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

1. Approximate date the employee became disabled by pregnancy, childbirth or related medical condition:

_____

Probable duration of period(s) of disability:_____

2. Use the information provided by the employer in Section I to answer these questions. If no job description is provided, the employer fails to provide a job description, answer these questions based upon the employee's own description of her job functions.

Is the employee unable to perform work of any kind without undue risk to herself, to others, or the successful completion of her pregnancy? ____ No ____ Yes