Serious Health Conditions

"Serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more 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 or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an "inpatient" when a heath 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.

2. Absence Plus Treatment

(a) 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, 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

(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.

3. 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.

4. 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.).

5. 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.

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), or kidney disease (dialysis).

Note: Authority cited: Section 12935(a), Government Code. Reference: Section 12945.2, Government Code; California Genetic Information Nondiscrimination Act, Stats. 2011, ch. 261; Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; and 29 C.F.R. § 825. Appendix B, Form WH-380, as revised December 1994

11. **Time Off for Medical Appointments or Treatment**: Is it medically necessary for the employee/patient to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: ____ time(s) per ____week(s) ____month(s) **Duration:** ____hour(s) or ____ day(s) per appointment/treatment

ADDITIONAL INFORMATION:

____

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______________________________ ______________________

Signature of Health Care Provider **Date**

____

Medical License/Authorizing License Number

I certify that I am 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.

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

Note: Authority cited: Section 12935(a), Government Code. Reference: Section 12945.2, Government Code; California Genetic Information Nondiscrimination Act, Stats. 2011, ch. 261; Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; and 29 C.F.R. § 825.

When answering these questions, please keep in mind that the employee/your patient's need for care can include assistance with basic medical, hygienic, nutritional, safety, or transportation needs, or the provision of physical or psychological care.

5. Will the employee/patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ____No ____Yes

   Estimate the beginning and ending dates for the period of incapacity:
   Beginning: ________________ Ending: ________________

7. Is it medically necessary for the employee to miss work on an **INTERMITTENT** basis or requires a **REDUCED WORK SCHEDULE?**

   Date **Intermittent** Leave Begins: ____________ Date Intermittent Leave Ends: ______________

   Please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

   Frequency: ____ time(s) per _____week(s) _____month(s) Duration: _____hour(s) or ____ day(s) per episode

8. If the employee/patient has requested leave on an intermittent or reduced schedule leave basis (please see the employee's/patient's response to the nature of the requested leave), is it medically necessary for the employee/patient to receive necessary medical care on an intermittent basis, including any time for recovery? ____No ____Yes

   If yes, estimate the hours of needed care by the employee/patient:

   _______ Hours per Day _______ Days per Week From: __________ through: _____________

9. If the patient has requested leave on an intermittent basis for anticipated flare ups (please see the employee's/patient's response to the nature of the requested leave) will the condition cause or contribute to episodic flare-ups periodically preventing the patient from performing his/her job functions? ____No ____Yes

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____No ____Yes
   If yes, explain: ____

   Please estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 12 months (e.g., 1 episode every 3 months lasting 1-2 days)

   Frequency: ___ times per _____week(s) _____month(s)

   Duration: _____ hours or _____ day(s) per episode

10. **Reduced Schedule Leave:** Is it medically necessary for the employee/patient to work less than the employee's normal work schedule due to the serious health condition of the employee?

    If yes, please indicate the part-time or reduced work schedule that is medically necessary:

    ___ hour(s) per day; ___days per week, from _________ through __________

SECTION III - To be Completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee/your patient has requested leave under the FMLA and CFRA to address his/her own physical or mental condition. Please fully and completely answer all applicable parts below. 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 "unknown," or "indeterminate" may not be sufficient to determine FMLA-CFRA or eligibility rights. Limit your responses to the condition for which the employee/patient needs care which may be covered under the FMLA or similar laws, **but do not disclose to us the actual diagnosis, symptoms or medical condition for which you are providing treatment unless expressly authorized in writing by the patient**. **Please also do not provide information concerning family medical history.**

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. Please answer fully and completely; terms such as "unknown," or "indeterminate" are not sufficient to determine FMLA/CFRA eligibility. Please be sure to sign the form on the last page.

Health Care Provider's name and business address: ______________________________

____

Type of practice: ______________________________

Telephone: (________)__________________________ Fax:(_________)______________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ______________________________

   Probable duration of condition: ______________________________

   Level of Treatment/Treatment Schedule per year: ______________________________

   Date of your last Examination/Treatment: ______________________________

2. Page 5 describes what is meant by a "serious health condition" under both the FMLA and CFRA. Does the patient's condition qualify under any of the categories described? ____No ____Yes

   If yes, which type of serious health condition listed on Page 5 applies: ____1 ____2 ____3 ____4 ____5 ____6

PART B: AMOUNT OF CARE NEEDED

3. Is the employee/patient able to perform the essential functions of his/her job? ____No ____Yes (Please see provided job description and contact the employer (Section 1, page 1) with any questions you may have regarding essential job functions or requirements.)

4 Is the employee/patient able to perform work of any kind? ____No ____Yes

   If yes, please identify below (restrictions should take in to consideration the employee's regular job duties and be specific as to physical, mental or medical limitations. A current job description or job task analysis is attached to this Certification. The District may be able to reasonably accommodate any medically necessary work restrictions in an alternate job assignment. Is the need for work preclusions or restrictions permanent? ____No ____Yes ______ Undetermined at this time.

5. Can the employee/patient work a reduced work schedule or perform essential job functions with reasonable accommodation(s)? ____No ____Yes If yes, describe all relevant work restrictions:

   ____

   ____

(continued on next page)

Certification of Health Care Provider for Employee's Serious Health Condition

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

PURPOSE of FORM Our employee/your patient has requested a leave of absence to attend to their own physical or mental condition that may qualify for protection under the FMLA and CFRA. This medical certification form provides us with necessary information to determine if the request falls within these statutes.

SECTION I - To be Completed by EMPLOYER

Employee's Name____

Employer's Name: ____

Employer's Contact & Contact Information: ________________________________

____

SECTION II - To be Completed by EMPLOYEE/PATIENT

INSTRUCTIONS to EMPLOYEE **Please complete and sign Section II before giving this form to your health care provider along with a copy of your job description** (obtain from your supervisor or Human Resources). To support your request for family medical leave, you are required to submit a timely, complete, and sufficient medical certification relating to your serious physical or mental condition. Failure to meet this requirement may result in a delay or denial of your leave request and/or discipline.

You must return this completed form within 15 calendar days of your request for leave. You or the physician may return this form to us in person, by mail, or by facsimile. The fax number is ________________________. If sent by mail or facsimile, the transmitting envelope or document should indicate "CONFIDENTIAL DISABILITY LEAVE INFORMATION" and directed to the District representative above. By signing this form, you are authorizing the health care provider to provide us with this necessary information and for us to contact the health care provider should the form be provided to us in an unclear or incomplete manner.

I have requested medical leave from my employer as follows:

1. The following specific days/partial days from work: ______________________________
2. Continuous Leave: starting (date): ____________ and ending (date): ____________
3. Intermittent or Reduced Schedule Leave starting (date): ____________, with anticipated periods of absence (days/blocks of time, "every Friday," etc.) as follows:

   ____
4. Reduced Regular Work Schedule: I need to reduce my work week hours to ______________________

   Starting (date): ______________ and ending (date): _______________
5. Intermittent absences for foreseeable flare ups of condition: _________________________

____ ____________________

Employee Signature **Date**