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

Date **Intermittent** Leave Begins: _____ Date Intermittent Leave Ends: _____

Is it medically necessary for the employee to be off work on an **INTERMITTENT** basis or requires a **REDUCED WORK SCHEDULE** to care for the family member? _____ No _____ Yes

If yes, 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: ____ times per _____week(s) _____month(s) Duration: _____hours or ____ day(s) per episode

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

   If yes, please indicate the part-time or reduced work schedule the employee needs:
   ___ hour(s) per day; ___days per week, from _____ through _____

9. **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, either by the health care practitioner or another provider of health services? _____ No _____ Yes

   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: ____ times per _____week(s) _____month(s) Duration: _____hours or ____ day(s) per appointment/treatment

_____ _____

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.

SECTION III - TO BE COMPLETED BY HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER The employee listed above has requested leave under the FMLA and/or governing state laws in order to care for your patient. 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 or similar coverage rights. Limit your responses to the condition for which the patient needs the employee's care, **but do not disclose to us the actual diagnosis or medical condition for which you are providing treatment.**

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: _____

2. Page 4 describes what is meant by a "serious health condition" under both the FMLA and California 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 3 applies: ____1 ____2 ____3 ____4 ____5 ____6

EMPLOYEE NEEDING FAMILY LEAVE ****TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER.

3. Employee must provide a signed statement to the family member's physician listing the type of care he/she will be providing to his/her family member, with the information noted below. Did you receive a written and signed statement from our employee? ____No ____ Yes

4. After review of the employee's signed statement, does the condition warrant the participation of the employee? ____ No ____ Yes *(This participation may include psychological comfort and/or arranging for third-party care for the family member.)*

   Please Estimate the period of time care needed or during which the employee's presence would be beneficial:

   _____

PART B: AMOUNT OF CARE NEEDED

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

5. Will the patient be incapacitated (unable to perform basic medical, hygiene, nutritional needs, safety or transportation) for a single continuous period of time, including any time for treatment and recovery?
   ____No ____Yes If "Yes," the period of incapacity will begin _____ and end on _____

6. During the period of incapacity, does or will the patient's condition warrant or require the participation of the employee in tending basic needs of your patient? (In answering this question, please review the employee's statement of care and/or expected care on pg. 1)
   ____No ____Yes

7. Please answer the following question only if the employee needs leave on an **INTERMITTENT** basis or requires a **REDUCED WORK SCHEDULE.**

Certification of Health Care Provider for Family Member's Serious Health Condition

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

PURPOSE of FORM Our employee has requested a leave of absence to care for a family member that may qualify for protection under the FMLA and/or governing state law. 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

INSTRUCTIONS to EMPLOYEE Please complete and sign Section II before giving this form to your family member or his/her health care provider. To support your request for family medical leave, you are required to submit a timely, complete, and sufficient medical certification relating to your family member's serious health 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 envelope or document should indicate "CONFIDENTIAL DISABILITY LEAVE INFORMATION" and be directed to the District representative identified above.

Name of family member for whom you are providing/will provide care: _____

Relationship to employee: ☐ spouse ☐ Registered Domestic Partner (CFRA) ☐ parent ☐ minor child ☐ adult child (*Care of Adult Dependent Child* **who is incapable of self-care because of a mental or physical disability within the meaning of Government Code section 12926(j) and (l)** *Requires active assistance or supervision in three or more activities of daily living (ADLs) or instrumental activities of daily living (IADLS).*

Describe the reasonable and necessary care/expected care you will provide to your family member:_____

_____

_____

_____

Please describe the nature of the requested leave (full time leave for a specific period of time, providing start and end dates; intermittent leave specific days/hours, etc.) needed to provide necessary care.

_____

I certify that the statements made by me are true and correct to the best of my knowledge.
An employee who fraudulently obtains or uses FMLA/CFRA leave from an employer is not protected by FMLA/CFRA's job restoration or maintenance of health benefits provisions. An employer has the burden of proving that the employee fraudulently obtained or used FMLA/CFRA leave.

_____ _____

Employee Signature **Date**