

<u>Employee Last Name</u>	<u>Employee First Name</u>	<u>Employee Middle Name</u>
Provider Name (You may attach a business card in lieu of completing this section)		
Business Address	City	State Zip Code
Type of Practice / Medical Specialty		
Telephone	Fax	

Part C. Medical Facts

1. Does the patient have a serious health condition that qualifies under the categories described on the attached sheet?
 Yes No If no, sign and date page three and return to patient.
2. If the patient has a serious health condition as defined in the attached sheet, please answer the following:
 - Approximate Date Condition Commenced: _____
 - Probable Duration of Medical Condition or Need for Treatment: _____
3. Dates treated for condition: _____
4. Will the patient need to have treatment visits at least twice per year due to the condition? Yes No
5. Was medication (other than over-the-counter) prescribed? Yes No
6. Does the condition of the patient warrant the participation of the employee? (This may include psychological comfort and or arranging for third party care for the family member) Yes No

Part D. Amount of Care Needed

When answering these questions, keep in mind the patient's need for care by the employee seeking leave may include assistance for basic medical, hygiene, nutritional, safety, transportation needs, the provision of physical or psychological care.

1. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes No
If yes, state the frequency and expected duration of such treatment(s):

2. Will the patient be incapacitated for a **single continuous period** of time due to his/her medical condition, including any time for treatment and recovery? Yes No
If yes, estimate the period of incapacity. beginning date: _____ ending date: _____
3. Will the patient require follow-up treatment, including any recovery time? Yes No
If yes, estimate the schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period.

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4. During this time, will the patient need care which the employee's presence would be beneficial?

Yes No

If yes, explain the care needed by the patient and why such care is **medically necessary**

5. **Please answer the following questions only if the employee is requesting intermittent leave or a reduced work schedule.**

Is it **medically necessary** for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to care for the serious health condition of the family member? Yes No

If yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment(s): _____ hour(s) per day; _____ days per week from _____ through _____

6. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? 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 (i.e., 1 episode every 3 months lasting 1-2 days):

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

Duration: _____ hours _____ day(s) per event

Does the patient need care during these flare-ups? Yes No

ADDITIONAL INFORMATION- Identify question number with any additional information

Please attach a separate sheet of paper if additional space is needed.

Signature below verifies that the information provided above is true and accurate.

Health Care Provider Signature

Date

Dear Health Care Provider,

Do NOT Provide the patient's diagnosis without the consent of the patient.

The employee has requested leave under the Federal and/or California family and medical leave statutes for the purpose of caring for your patient (who is a parent, child, or spouse/domestic partner of the employee).

Thank you for your assistance.

Employee Last Name

Employee First Name

Employee Middle Name

Definition of a Serious Health Condition

Serious health condition is any illness, injury, impairment, physical or mental condition that involves:

1. Any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or
2. Continuing treatment by a health care provider for one or more of the following:
 - a. Any period of incapacity due to a chronic serious health condition that:
 - i. Requires periodic (at least two visit per year) visits for treatment
 - ii. Continues over an extended period of time; and
 - iii. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
3. Any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease)
4. Any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition.

A Serious Health Condition is Generally Not:

1. Allergies, stress, or substance abuse unless inpatient hospital care is provided, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health condition; or
2. Voluntary treatment or surgery inpatient hospital care is required.

A Health Care Provider Is:

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker, physicians assistant, who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner. A health care provider also is any provider from whom the University or the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.

Privacy Notice

This notice is provided pursuant to the Information Practices Act of 1977.

The California Department of Human Resources (CalHR), Personnel Management Division is requesting the information specified on this form. The information collected will be by your department for purposes of determining your eligibility for FMLA/CFRA benefits.

Individuals should not provide personal information that is not requested or required.

The submission of all information requested is mandatory unless otherwise noted. If you fail to provide the information requested, there may be a delay in processing your request.

Department Privacy Policy

The information collected by CalHR is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please read our Privacy Policy on CalHR's website (calhr.ca.gov).

Access to Your Information

Information provided on this form will be maintained by the CalHR Personnel Management Division pursuant to State Administrative Manual retention requirements. Individuals have the right of access to copies of this form on request. Send requests to:

Personnel Management Division
Department of Human Resources
1515 S Street, Suite 500N
Sacramento, CA 95811

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS



Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

BENEFITS & PROTECTIONS

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

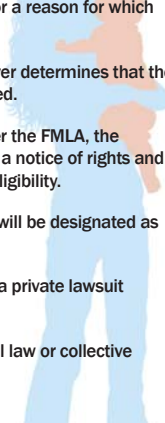
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.



For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

