California State University San Marcos Corporation **Medical Certification**

EMPLOYEE NAME_____

PATIENT'S NAME (if other than employee): Print _____

Relationship to employee:_____

❑ CERTIFICATION THAT EMPLOYEE REQUIRES TIME OFF WORK BECAUSE OF A SERIOUS HEALTH CONDITION (see definition attached)

(NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT) This form may be returned to the employee, mailed or faxed back – information is listed on second page.

Is patient unable to work because of a serious health condition? ◯No ◯Yes

(If the patient is pregnant, please list the due date and expected date that the patient could return to work)

Date Condition Commenced: First Day Off:

Anticipated Return to Work Date:

Was patient hospitalized? ◯No ◯Yes Can employee perform any work? ◯No ◯Yes

Is it medically necessary for the employee to be off work on an intermittent basis? ◯No ◯Yes

If yes, indicate required schedule (include days and times): _____

❑ CERTIFICATION OF NEED TO CARE FOR THE EMPLOYEE'S FAMILY MEMBER (child, spouse, or parent) WITH A SERIOUS HEALTH CONDITION (see definition attached)

Please state reasons that warrant employee care of their family member during period of treatment:

_____

Estimate the period of time required of employee to care for the family member: _____

First Date Time Off Is Required:	Expected Return to Work Date:

Is it medically necessary for the employee to be off work on an intermittent basis in order to care for the family member? ◯No ◯Yes (If yes, indicate days and times required off)

_____

❑ CERTIFICATION THAT EXTENSION OF LEAVE IS REQUIRED

Extend Leave until (date): _____

Health Care Provider Signature		Date
Print Name	Company/Organization Name	
Street Address		
City	State	Zip
Phone #	License Number	

SERIOUS HEALTH CONDITION

A "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, domestic partner 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:

HOSPITAL CARE Inpatient care 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 health care facility formally admits the person to the facility with the expectation that the person 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.

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:

1. Treatment two or more times by a health care provider (for FMLA only, the two treatments must occur within 30 days ***), 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. For FMLA only, the employee's first treatment must occur within 7 days of first day of incapacity. ***

PREGNANCY Any period of incapacity due to pregnancy or for prenatal care. (Note: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.)

CHRONIC CONDITIONS REQUIRING TREATMENT A chronic condition, which: 1. Requires periodic visits (for FMLA ONLY, periodic means at least two times per year ***) 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.).

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.

MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS) Any period of absence to receive multiple treatments (including any period of recovery there from) 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 treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis). *** California law does not include these time limitations. If a leave is FMLA/CFRA, follow the California law without these time limitations. 1. Treatment two or more times by a health care provider (for FMLA only, the two treatments must occur within 30 days ***), 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. For FMLA only, the employee's first treatment must occur within 7 days of first day of incapacity

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Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

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Attachment B: Employee's Statement Regarding Seriously Ill Family Member

To be completed and signed by the employee needing family leave to care for a seriously ill family member. Employee should provide this section to the health care provider under separate cover. This information is NOT to be provided to the employer.

If you are seeking leave to care for a seriously-ill family member, please provide a description of the care you will provide for your family member (include an estimate of the time period during which this care will be provided and a schedule if leave is to be taken intermittently or on a reduced work schedule):

I certify that the information I have provided is true and correct.

_____ _____

Signature of Employee Date

_____

Print Name Here