CERTIFICATION OF HEALTH CARE PROVIDER
FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

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

PURPOSE of FORM: The below-named employee has requested a leave of absence to care for a family member with a health condition, which may qualify as a protected leave under the FMLA and/or CFRA. This medical certification form will provide the University with information needed to determine if the employee's requested leave is for a qualifying reason under the FMLA and/or CFRA. Section III must be fully completed by the health care provider.

INSTRUCTIONS to EMPLOYEE: Please complete and sign Section II before giving this form to your family member or his/her health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA and/or CFRA leave due to your family member's serious health condition. Providing this completed form is required to obtain (or retain) the benefit of FMLA and/or CFRA protections for your leave. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days of our request for this information. If you cannot return the completed form within the stated deadline, please contact gmebenefits@ucsd.edu with the reasons for the delay and the date when the certification will be provided.

You may return the form in person, by mail, or by fax. The fax number is (619) 543-2990

You should include a fax cover sheet marked "CONFIDENTIAL" and address your fax to:

"ATTENTION: GME - Benefits Coordinator."

SECTION I – To be completed by THE UNIVERSITY

EMPLOYEE'S NAME	EMPLOYEE'S JOB TITLE
	Resident

EMPLOYEE'S REGULAR WORK SCHEDULE

Varies

NAME OF UNIVERSITY REPRESENTATIVE	UNIVERSITY REPRESENTATIVE MALING ADDRESS
	200 W. Arbor Drive, San Diego, CA 92103-8829

TELEPHONE	FAX	E-MAIL
(619) 543-7820	(619) 543-2990	gmebenefits@ucsd.edu

SECTION II – To be completed by EMPLOYEE

Name of family member for whom you will provide care:	Relationship of family member to you:

If family member is your child, date of birth: _____|_____|_____

If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability? ☐ Yes ☐ No

(1) Describe care you will provide to your family member and estimate the duration of leave needed to provide care.

(2) Are you requesting leave on an intermittent or reduced schedule basis? ☐ Yes ☐ No

If yes, please describe the leave schedule you are requesting:

SIGNATURE

EMPLOYEE SIGNATURE	DATE

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 CFRA to care for your patient. Please answer, fully and completely, 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 "indefinite," "unknown," or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage. **Limit your responses to the condition for which the patient needs the employee's care.** Please be sure to sign and date the form on Page 2.

PROVIDER'S NAME

BUSINESS ADDRESS

TELEPHONE	FAX
( )	( )

PART A: MEDICAL FACTS

(1) Approximate date condition commenced:

____ __|_____|_____

Probable duration of condition:

From: _____|_____|_____ To: _____|_____|_____

(2) Page 3 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? ☐ Yes ☐ No

If yes, which type of serious health condition listed on Page 3 applies:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

PART B: AMOUNT OF CARE NEEDED

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

(1) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

Estimate the beginning and ending dates for the period of incapacity:

Beginning: _____|_____|_____ Ending: _____|_____|_____

During this time, does the patient's condition warrant the participation of the employee? (In answering this question, please review the employee's statement of care in Section II, page 1.) ☐ Yes ☐ No

(2) If the employee has requested leave on an intermittent or reduced schedule leave basis (see answer in Section II, page 1, question 2), is it medically necessary for the patient to receive care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

If yes, estimate the hours the patient needs care from the employee:

_____ Hours per Day _____ Days Per Week From: _____|_____|_____ through: _____|_____|_____

SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER	DATE

Serious Health Conditions

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 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

(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 (only covered under FMLA)

A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.

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), or kidney disease (dialysis).