California Department of Human Resources

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

CalHR 754 (Rev 2/13)

Reset Form | Print Form

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

Part A: For Completion by the person responsible for administering the leave program in your department who will be the Department Contact.

Instructions: Complete Section I before giving this form to the employee.

Employee Last Name _____ Employee First Name _____ Employee Middle Name _____ Last Day Worked: _____

Employee Classification _____ Employee Work Unit _____

Department Contact _____ Department Contact Phone _____

Attach a copy of the employee's job description and the essential job functions of the employee's position.

Part B: For Completion by the EMPLOYEE

Instructions to the Employee: Part A must be completed by the person responsible for administering the leave program in your department and you must complete Part B before giving this form to your medical provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in denial of your leave request. **You have 15 calendar days to return this form.**

Daytime Contact Phone Number: _____

Regular Work Schedule

☐ Days ☐ Nights ☐ Full Time ☐ Part Time

☐ 9/80 ☐ 4/10 ☐ Other _____

Part C: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS for the HEALTH CARE PROVIDER: Your patient has requested leave under FMLA/CFRA. Please answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience and examination of the patient. Please be as specific as you can; terms such as “lifetime,” “unknown” or “indeterminate may not be sufficient to determine FLMA/CFRA coverage. **Please do not disclose the underlying diagnosis without the consent of your patient. Please limit responses to the condition for which the employee is seeking leave. Please be sure to sign and date the form on the last page**

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 D. 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 two 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: _____

3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No If yes, date of admission _____

4. Dates treated for condition: _____

5. 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): _____

Employee Last Name _____ Employee First Name _____ Employee Middle Name _____

6. Is the employee unable to perform any of the job functions due to his/her medical condition? (See attached Essential Job Functions and/or attached Job Description): ☐ Yes ☐ No
If yes, identify the job functions the employee is unable to perform, work restrictions and probable duration:

7. Can the patient perform modified duty? ☐ Yes ☐ No
If yes, state the type of modified duty the employee is able to perform and probable duration:

Part E: Amount of Time Needed

1. Will the employee 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 beginning and ending dates for the period of incapacity:

2. Will the employee need to attend follow-up treatment appointments because of the employee's medical condition? ☐ 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

3. Will the employee need to work part time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No
If yes, estimate the part-time or reduced work schedule the employee needs
_____ hour(s) per day; _____ days per week from _____ through _____

4. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No
If yes, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):
Frequency: _____ times per _____ week (s) _____ month(s)
Duration: hours day(s) per event

ADDITIONAL INFORMATION (Identify Question Number With Any Additional Information to Your Answers)

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

Printed Name of Health Care Provider

_____

Health Care Provider Signature _____ Date _____

Employee Last Name Employee First Name Employee Middle Name

_____ _____ _____

Dear Health Care Provider,

Do NOT provide the employee's diagnosis.

The employee has requested leave under the Federal and/or California family and medical leave statutes for his or her own serious health condition.

Thank you for your assistance.

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 pregnancy, for prenatal care.
   b. 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 that would likely result in a period of incapacity of more than three consecutive calendar days in the absence or medical intervention such as cancer (chemotherapy, radiation, etc., or kidney disease (dialysis) or severe arthritis (physical therapy).

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 conditions; 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

1. 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.
2. any provider the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.

PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) requires this notice be provided when collecting personal information from individuals.

Information requested on this form is used by your department for purposes of determining your eligibility for FMLA/CFRA benefits. It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in a delay in processing your request.