California Department of Human Resources

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

CalHR 755 (Rev 2/13)

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

Part A: For Completion by the Employee

Instructions to the EMPLOYEE: Please Complete Part A before giving this form to your family member or his/her health care provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support a request for leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your leave request. **You have 15 calendar days to return this form.**

Employee Last Name _____ Employee First Name _____ Employee Middle Name _____ Contact Telephone Number _____

Employee Classification _____ Employee Work Unit _____

Last Day Worked _____

Regular Work Schedule
☐ Days ☐ Nights ☐ Full Time ☐ Part Time
☐ 9/80 ☐ 4/10 ☐ Other _____

Relation to employee ☐ child/child of domestic partner ☐ spouse ☐ parent ☐ domestic partner

If family member is your son or daughter , date of birth

Name of family member for who you will provide care Last Name _____ First Name _____ Middle Name _____

Describe the care you will provide to your family member and estimate how much you will need take to provide the care:

_____

Employee Signature: I certify that the information I have provided is true and correct. Date

_____ _____

Part B: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS for the HEALTH CARE PROVIDER: The employee listed above has requested leave under FMLA/CFRA to care for your patient. 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 which the employee is seeking leave for the family member. 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 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 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: _____ Probable Duration of Medical Condition or Need for Treatment: _____

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

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 medication 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 beginning and ending date for the period of incapacity _____ to _____

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 _____

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..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 to Your Answers) Please attach a separate sheet of paper if additional space is need.

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

Health Care Provider Signature _____ Date _____

Employee Last Name	Employee First Name	Employee Middle Name

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.

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 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 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

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.