Human Resource Services

Family Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL)

MEDICAL CERTIFICATION – EMPLOYEE'S SERIOUS HEALTH CONDITION

EMPLOYER: **Palomar Community College District**
EMPLOYEE'S JOB TITLE:
EMPLOYEE'S JOB DESCRIPTION IS ATTACHED.

INSTRUCTIONS TO THE EMPLOYEE:

The FMLA, PDL, and CFRA permit an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA, CFRA, and/or PDL leave due to your own serious health condition and/or pregnancy or childbirth related disability. Your response is required to obtain or retain the benefit of FMLA, CFRA, and/or PDL protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA, CFRA, and/or PDL request. Your employer must give you at least 15 calendar days to return this form.

EMPLOYEE NAME: SIGNATURE:

INSTRUCTIONS TO THE HEALTH CARE PROVIDER:

Your patient has requested leave under the FMLA, CFRA, and/or PDL. Answer, fully and completely, all applicable parts. 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 "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA, CFRA, and/or PDL coverage. Limit your responses to the condition for which the employee is seeking leave. **Please be sure to sign the form on the last page.**

HEALTH CARE PROVIDER NAME:

HEALTH CARE PROVIDER ADDRESS:

TYPE OF SPECIALTY:

TELEPHONE NUMBER:

MEDICAL FACTS: (To be completed by the Health Care Provider)

NOTE: The health care provider is NOT to disclose the underlying diagnosis, please address the specific physical or psychological restrictions that impact the employee's ability to perform their regular job duties. Please use the enclosed job description to provide detailed responses to the following questions.

☐ **This employee will be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery.**

Please estimate the beginning and ending dates for the period of incapacity:

Begin date of Leave: Expected Return Date:

☐ **This employee needs to be off work on an intermittent basis, or to work a reduced number of hours in order to deal with the employee's serious health condition.**

Are the treatments, or reduced number of hours of work medically necessary? ☐ Yes ☐ No

Please estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Please estimate the part-time or reduced work schedule the employee needs, if any:

Hour(s) per day   Days per week   Start date: End date:

Will the employee's serious health condition cause episodic flare-ups periodically preventing the employee from performing his/her regular job duties? ☐ Yes ☐ No

Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

Please explain:

Based upon the employee's medical history, and your medical knowledge, please estimate the frequency of the flare-ups and the duration of incapacity over the next 3 months:

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

Duration: hours or   day(s) per episode

Is employee's serious health condition permanent? ☐ Yes ☐ No

If yes, could employee benefit from an accommodation? ☐ Yes ☐ No

FOR INTERMITTENT FMLA, CFRA, and/or PDL LEAVES:

Please provide facts about relevant medical restrictions, physical or psychological, that are related to the serious health condition for which the employee requires intermittent leave. This information should provide the District with a clear understanding of any accommodations that may need to be provided in order to safely support the employee while at work.

SIGNATURE OF HEALTH CARE PROVIDER   DATE