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

MEDICAL CERTIFICATION – FAMILY MEMBER'S SERIOUS HEALTH CONDITION

EMPLOYER: **Palomar Community College District**

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 the serious health condition and/or pregnancy or childbirth related disability of the employee's family member. 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:

PATIENT'S NAME: RELATION TO EMPLOYEE:

INSTRUCTIONS TO THE HEALTH CARE PROVIDER:

Your patient's family member 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 family member 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 family member's ability to perform their regular job duties. Please use the enclosed job description to provide detailed responses to the following questions.

☐ **This patient 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 duration of the medical condition or need for treatment:

Begin date of condition: Expected recovery date:

☐ **This patient needs their family member to provide medically necessary care on an intermittent basis.**

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 needed to support the patient, if any:

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

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

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

Please explain:

Based upon the patient'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

PLEASE CHECK THE CATEGORY OF CONDITION WHICH APPLIES TO YOUR PATIENT:

- ☐ **Hospital Care:** Inpatient care, hospice, residential medical care
- ☐ **Absence:** Period of incapacity greater than three consecutive days, with subsequent treatment
- ☐ **Pregnancy**
- ☐ **Chronic Conditions Requiring Treatments**
- ☐ **Permanent/Long-term Conditions Requiring Supervision**
- ☐ **Multiple Treatments (Non-Chronic Conditions)**

SIGNATURE OF HEALTH CARE PROVIDER DATE