SJSU SAN JOSÉ STATE UNIVERSITY

University Personnel
Payroll and Benefits
Leave Programs

University Personnel South
UPD Building Third Floor
One Washington Square
San José, CA 95192-0046

TEL: 408-924-2155
FAX: 408-924-2144
www.sjsu.edu/up/

MEDICAL CERTIFICATION FOR FAMILY MEDICAL LEAVE

California State University Family Medical Leave (CSU FML)

California State University (CSU) Family Medical Leave (FML) incorporates both the Federal Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) leave entitlements, which in most cases run concurrently. The Family and Medical Leave Act (FMLA) permits an employer to require that an employee seeking FML protections because of a need for leave to support their own serious health condition, or to care for a covered family member with a serious health condition to submit a medical certification issued by the appropriate health care provider. Your response is required to obtain or retain the benefit of FML protections. You must return this completed form within 15 calendar days after your request to determine eligibility for your leave. Failure to provide a complete and sufficient medical certification may result in a denial of your FML request. The information sought on this form pertains only to the condition for which the employee is requesting leave from work.

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

Section I. For completion by EMPLOYEE

The request for medical leave is for ☐ employee ☐ family member* – complete statement of family member care

Names: Employee_____Patient:_____
First, Last, M.I. First, Last M.I.

Patient's relationship to employee: _____ Is patient under 18 or an adult dependent child? ☐Yes ☐No

***EMPLOYEE STATEMENT OF FAMILY MEMBER CARE**

Provide a description of the care you will provide for your seriously-ill family member. (For assistance, review the following questions asked of the health care provider (SECTION II) to support your statement.)

_____

_____

_____

_____

Employee signature: _____ Date:_____

Section II. For completion by HEALTH CARE PROVIDER

NOTE: If medical leave is for employee's FAMILY MEMBER, by completing this section, you acknowledge that you have reviewed the employee's signed and dated **EMPLOYEE STATEMENT OF FAMILY MEMBER CARE** above. Please answer, fully and completely, applicable parts below.

Medical Facts
The following is a list of serious health conditions. (Please see page three (3) for a description of what constitutes a "serious health condition" under applicable law. Do not disclose the underlying diagnosis without consent of the patient.)

- Hospital care Absence plus treatment
- Pregnancy
- Chronic conditions requiring treatment

- Permanent/Long-term conditions requiring supervision
- Multiple treatments (non-chronic conditions)

1. Does the patient's condition qualify as a serious health condition? ☐ Yes ☐ No* – see following instructions
*If **no**, do not proceed with questions. Complete Health Care Provider Information on page two (2) and provide to the employee to submit to the Leave Program Manager.

2. Date medical condition or need for treatment commenced: _____.

3. Probable duration of medical condition or need for treatment: _____.

If patient is EMPLOYEE	If patient is FAMILY MEMBER
4a. Is patient able to perform work of any kind? ☐ Yes ☐ No **5a.** Is patient unable to perform any one or more of the essential functions of their position? ☐ Yes ☐ No ▪ The essential functions of the employee's position was communicated to you in: ☐ Writing: position description from employee ☐ Verbal: discussion with the employee	**4b.** Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ☐ Yes ☐ No **5b.** Estimate the period of time the patient will need care during which the employee's presence would be beneficial to participate in care for the patient: _____.

Please answer the following questions only if the employee is asking for intermittent leave or a reduced work schedule.

6. *Intermittent Leave:* Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee or family member? ☐ Yes – answer 6 a. ☐ No – not applicable

6a. If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):
Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hours or _____ day(s) per episode

7. *Reduced Schedule Leave:* Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee or family member? ☐ Yes – answer 7a. ☐ No

7a. If yes, please indicate the part-time or reduced work schedule that is recommended:
Frequency: _____hour(s) per day; _____days per week, from _____ through _____.

8. *Time Off for Medical Appointments or Treatment:* Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?
☐ Yes – answer 8 a. ☐ No

8a. If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:
Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hours or _____ day(s) per appointment/treatment

HEALTH CARE PROVIDER INFORMATION

Name: _____ Specialty:_____ License No. _____

Medical Facility/Address: _____

Tel. _____ Fax: _____ Signature: _____ Date: _____

I hereby certify that the information provided is true and accurate to the best of my knowledge.

Adapted and modified from the California Department of Fair Employment and Housing Form DFEH-E11P-ENG/July2017

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DESCRIPTION OF SERIOUS HEALTH CONDITION

"Serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

HOSPITAL CARE
Inpatient care 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. A person is considered an "inpatient" when a health care facility formally admits them to the facility with the expectation that they will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

ABSENCE PLUS TREATMENT
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:
1. 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
2. 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.

PREGNANCY
Any period of incapacity due to pregnancy or for prenatal care. *An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA*

CHRONIC CONDITIONS REQURING TREATMENT
A chronic condition, which:
1. Requires periodic visits for treatment by a health care provider, or by a nurse of physician's assistant under direct supervision of a health care provider;
2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and 3. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

A period of incapacity which 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.

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).