SJSU SAN JOSÉ STATE UNIVERSITY

FAMILY MEDICAL LEAVE CERTIFICATION (FML)

HUMAN RESOURCES | 408-924-2250 | 408-924-1701 (fax)

Purpose of the Form

CSU 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 of your request. Failure to provide a complete and sufficient medical certification may result in a denial of your FML request.

Employees Instructions:

Please complete section I before giving this form to your health care provider or your family member's health care provider.

Section 1. For completion by the EMPLOYEE		
Employee Name:	Employee ID:	Home Phone:
Current Mailing Address:		
Name of family member for whom you will provide care (if applicable):		
Family member relationship (if applicable):		
Department/College Name:	Campus Phone:	
I authorize the health care provider to complete this form and provide the information requested by San Jose State University. **NOTE:** The information sought on this form pertains **only** to the condition for which the employee is requesting leave from work.		
Employee Signature	Date	

Health Care Provider Instructions:

The employee listed above has requested leave under the FML for their own illness or to care for your patient, listed as their family member. Answer, fully and completely, all applicable parts below. 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 FML coverage. Limit your responses to the condition for which the employee or patient needs leave. Please be sure to sign the form on the last page.

Section II. For completion by the HEALTH CARE PROVIDER

Part A: Medical Facts

1. Approximate date condition commenced _____________ Probable duration _______________

   Dates you treated the patient for condition ____

2. Page 4 describes what is meant by a "serious health condition". Does the patient's condition qualify under any of the categories described? ☐ No ☐ Yes
   If yes, which type of serious health condition listed on page 4 applies: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

3. If the patient’s serious health condition is listed as **type 3** (as defined on page 4) please provide the expected delivery date ________________

4. If the patient’s serious health condition is **type 2** (as defined on page 4), did the patient visit a health care provider within 7 days of his/her first day of incapacity? ☐ No ☐ Yes

5. If the patient’s serious health condition required at least two visits to a health care provider, was the second visit to a health care provider within 30 days of the patient’s first day of incapacity? ☐ No ☐Yes

6. If the patient’s serious health condition is **type 4** (“chronic condition” as defined on page 4), will the condition require two or more visits to a health care provider per year? ☐ No ☐ Yes

7. Is the reason for this leave catastrophic in nature, totally incapacitating the patient from work? A chronic condition for an employee illness may also be considered catastrophic, even if the condition results in only intermittent absences. A condition, which is short term in nature, such as a cold, flu, or minor injury, is generally not deemed catastrophic. ☐ No ☐ Yes

8. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the definition of a serious health condition. (such medical facts may include symptoms, nature of illness/ injury or any regimen of continuing treatment such as the use of specialized equipment.)

(Employee Illness Only) Mark all that apply

1. Is the patient unable to perform any of his/her job functions due to the condition: ☐ No ☐ Yes
   If yes, identify the job functions the patient is unable to perform:

2. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., Physical therapist)?
   ☐ No ☐ Yes
   If yes, state the nature of such treatments and expected duration of treatment:

3. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐Yes

   Beginning date ____________ End date _____________ Anticipated return to work date____________

4. Will the patient be incapacitated on an intermittent or reduced schedule basis, including any time for recovery?
   ☐ No ☐ Yes. Estimate the intermittent or reduced schedule, if any (indicate time off work):

   _________ hour(s) per day; ________ Days per week From ______________ through ______________

   Workload reduction (Faculty) ___________%

5. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes

6. Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ No ☐ Yes.
   If yes, explain:

7. Based upon the patients' 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 (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

(Family Care Only) Mark all that apply

1. Will the patient require care for a single continuous period of time, including any time for treatment and recovery?
   ☐ No ☐ Yes

   Beginning date ____________ End date _____________ Anticipated return to work date____________

2. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
   ☐ No ☐ Yes Estimate the hours the patient needs care on an intermittent basis, if any:

   _________ hour(s) per day; ________ Days per week From ______________ through ______________

   Workload reduction (Faculty) ___________%

3. Explain the care needed by the patient and why such care is medically necessary:

4. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ Yes

5. Does the patient require care during these flare-ups? ☐ No ☐ Yes
   If yes, explain the care needed by the patient, and why such care is medically necessary:

6. 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 (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

HEALTH CARE PROVIDER INFORMATION	
Name of Health Care Provider:	Specialty:
Address:	Phone:
State License Number:	Licensed to practice in the state(s) of:
Signature:	Date:

DEFINITION OF SERIOUS HEALTH CONDITION

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For the purposes of FML, “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Inpatient Care
Inpatient care (i.e., an overnight stay) 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.

2. Incapacity of More Than 3 Consecutive Days Plus Continuing Treatment by a Health Care Provider
A period of incapacity of more than three consecutive calendar days and any subsequent treatment or period of In capacity relating to the same condition that also involves:

(a) Treatment two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse 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

(b) 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. The first in-person treatment visit must take place within seven days of the first day of incapacity.

3. Pregnancy
Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatment
Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:

(a) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse under direct supervision of a health care provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision
A period of incapacity that 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.

6. Conditions Requiring Multiple Treatments (Non-Chronic Conditions)
Any period of absence to receive multiple treatments (including any period of recovery there from) 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:

(a) Restorative surgery after an accident or other injury or

(b) 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), kidney disease (dialysis).