CITY OF CARSON

CERTIFICATION OF HEALTH CARE PROVIDER
EMPLOYEE'S OWN SERIOUS HEALTH CONDITION

Under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave Law (PDL) and/or applicable City Leave Policies

I. EMPLOYEE'S INFORMATION

Employee's Name	Employee's Date of Birth	Employee's Identification Number
Employee's Department	Employee's Job Title	Employee's Regular Work Schedule

II. EMPLOYEE'S SERIOUS HEALTH CONDITION

A. Nature of the Serious Health Condition (Select One):

☐ 1. Inpatient Hospital Care
(An overnight stay in a hospital, hospice or residential care facility, including periods of incapacity associated with this stay)

☐ 2. Incapacity and Treatment
(Treatment two or more times following a period of incapacity of more than three consecutive full calendar days)

☐ 3. Pregnancy, Due Date _____ ◯Actual ◯Estimated
(Any period of incapacity due to a pregnancy or recovery from childbirth, including pre- and post-natal care)

☐ 4. Chronic Condition
(A period of incapacity or treatment for a condition requiring regular provider visits/treatment, and continuing for an extended time)

☐ 5. Permanent or Long-Term Condition
(A period of incapacity or treatment due to a long-term condition under the continuing supervision of a provider)

☐ 6. Multiple Treatments for a Non-Chronic Condition
(A period of absence to receive multiple treatments for restorative surgery or a condition that would result in incapacity if not treated)

☐ 7. None of the Above – Explain:
_____

B. Medical Facts about the Serious Health Condition

(such as nature of incapacity, regimen of continuing treatment or follow-up appointments, etc. DO NOT INCLUDE DIAGNOSIS)

If chiropractor, is the treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray? ◯ Yes ◯ No

Is the employee able to perform work of any kind? If "NO", skip the next question.
◯ No ◯ Yes

Is the employee unable to perform any one or more of the essential functions of his/her position? Answer after reviewing statement from employer of essential functions, or if none provided, after discussing with the employee.
◯ No ◯ Yes

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III. REQUESTED TIME OFF WORK:

A. Will the employee be incapacitated for a single continuous period of time, including time for treatment and recovery.
◯ No ◯ Yes – provide start and end dates, below:

_____ _____ _____
Leave Start Date | Expected Leave End Date | Expected Return to work date

B. Will the employee need intermittent time off due to this serious health condition?
◯ No ◯ Yes – if Yes, are these absences medically necessary? ◯ No ◯ Yes, if so provide details below:

_____ _____
Intermittent Period Start Date | Intermittent Period End Date

Frequency: _____ hour/days per week/month, or: _____
Duration: _____ hours per day, or: _____
Will these absences be consecutive? No ◯ Yes ◯
-If yes, up to _____days in a row.

*if period end date is not known, please provide an estimated date that re-evaluation will occur.

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

Dates of Appointments	Time Required Per Appointment	Recovery Period Required

C. Will the employee need to work part-time or a reduced work schedule due to this serious health condition?
◯ No ◯ Yes - if yes, is this schedule medically necessary? ◯ No ◯ Yes, if so provide details below:

_____hours per work day, _____days per workweek

_____ _____
Reduced Schedule Start Date | Reduced Schedule End Date

IV. Limited Authorization for Release of Health Care Information

_____ _____
Employee's Name | Employee's Date of Birth

I authorize the release of any medical information necessary to complete this form. Knowingly providing false information directly, or through another party, may result in adverse action against the employee.

_____ _____
Employee's Signature | Date

CERTIFICATION BY PROVIDER: *By signing below you are certifying that the information you have provided is accurate and complete, and that this information is based on your personal knowledge of the patient's condition.*

_____ _____ _____
Provider's Printed Name and Credentials | Type of Practice | Telephone Number

_____ _____
Provider's Office Address (Street, City, State, Zip Code) | Best times & Days to Call

_____ _____
Provider's Signature (No stamps or Proxy Seals Accepted) | Date