CITY OF CARSON

CERTIFICATION OF HEALTH CARE PROVIDER
SERIOUS HEALTH CONDITION OF A QUALIFYING
FAMILY MEMBER/DESIGNATED PERSON

Under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA) 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. FAMILY MEMBER OR DESIGNATED PERSON FOR WHOM YOU WILL CARE FOR

_____	_____	_____
Name	Date of Birth	Relationship to Employee/Designated Person

Describe care you will provide to your family member and estimated leave time you will need to provide care:

_____

_____

_____

_____ _____

Employee's Signature Date

III. FOR COMPLETION BY THE FAMILY MEMBER'S OR DESIGNATED PERSON'S HEATH CARE PROVIDER:

The employee listed above has requested leave under FMLA to care for your patient. Answer fully and completely all the applicable parts below in regard to the identified family member, Be as specific as possible to allow the employee's employer to assess all the facts as to whether this leave qualifies under FMLA and the amount of leave needed.

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:_____

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IV. AMOUNT OF CARE NEEDED:

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

If end date cannot be estimated, will the employee require leave for at least 12 weeks? ○ No ○ Yes

_____ _____

Leave Start Date Expected Leave End Date

B. Will the patient require care on an intermittent basis due to this serious health condition?
○ No ○ Yes – if Yes, is this care medically necessary? ○ No ○ Yes, if so provide details below:

_____ _____

Intermittent Period Start Date Intermittent Period End Date

Frequency: _____ times per_____ week(s) _____ month(s)
Duration: _____ hours or _____ day(s) per episode
Will these absences be consecutive? No ○ Yes ○
-If yes, up to _____days in a row.

Describe the care needed by the patient, and why such care is medically necessary:

_____

_____

_____

C. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ○ No ○ Yes - if yes, does the patient need care during these flare ups? ○ No ○ Yes, if yes please estimate the frequency of flare ups and the duration of related incapacity:

Frequency: _____times per _____ month Duration: _____ hours or _____day(s) per episode

Describe the care needed by the patient, and why such care is medically necessary:

_____

_____

_____

V. Limited Authorization for Release of Health Care Information

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.

_____ _____ _____

Patient's Name Printed Patient'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.*

_____ _____ _____

Providers 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