CALIFORNIA STATE

# CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE

**Family Medical Leave Act (FMLA) & California Family Rights Act (CFRA)**

**Please complete this form and return to: CSU East Bay, Human Resources, 25800 Carlos Bee Blvd., SA 2600, Hayward, CA 94542 Phone (510) 885-3634 or Fax (510) 885-2951.**

## SECTION I – For Completion by the Employee

**EMPLOYEE: PLEASE COMPLETE SECTION I, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER**

Employee: Dates requested by employee: TO:

Job Title: Regular work schedule:

Employee Signature: Home Phone Date:

**EMPLOYEES ARE NOT TO COMPLETE SECTION BELOW**

## SECTION II - For Completion by the Health Care Provider ONLY

Your patient (our employee) has requested leave under the FMLA/CFRA. 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" are not sufficient to determine FMLA/CFRA coverage**. Limit your responses to the condition for which the employee is seeking leave.

**THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): The Genetic Information Nondiscrimination Act of 2008 (GINA)** prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**NOTE: DO NOT DISCLOSE THE EMPLOYEE'S UNDERLYING DIAGNOSIS WITHOUT HIS/HER CONSENT**

Does the patient's medical condition qualify under any of the "serious health condition" categories described under both the FMLA/CFRA? (See reverse side for definition) ☐ Yes ☐ No

If yes, please check the appropriate category(s): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Date medical condition or need for treatment commenced?

**Period of Time Required:** Based on the patient's medical history and your knowledge of medical condition, estimate the type of absence and period

If so - are there any essential functions the employee is not able to perform? (Answer after reviewing job description, or, if none provided, after discussing with employee) _____

Will the employee need to attend follow-up treatment or appointments because of the employee's medical condition? ☐ Yes ☐ No

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

Does the employee require other medical accommodations? If yes, please describe: ☐ Yes ☐ No

Name of Health Care Provider:_____ Specialty:_____

Address_____ Phone Number: _____

My Signature below verifies that the information provided above is true and accurate. Fax Number: _____