SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS: Please complete Section I before giving this form to your family member’s medical provider. The CSU FML permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for CSU FML leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of CSU FML protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a non-approval of your CSU FML request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

<table>
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<tr>
<th>Employee Name</th>
<th>Patient Name</th>
<th>Patient Relationship</th>
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When family care leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

________________________________________

SECTION II: For Completion by the HEALTH CARE PROVIDER

The employee listed above has requested leave under CSU FML to care for your patient. 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” may not be sufficient to determine CSU FML coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Please be sure to sign the form on the last page.

NOTE: The health care provider is not to disclose the underlying diagnosis without the consent of the patient. In addition, 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 as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

Provider's name and business address: ____________________________

Type of practice / Medical specialty: ____________________________

Telephone: (__________)  Fax: (_______)

The list below describes what is meant by a “serious health condition” under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). “Serious Health Condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

PLEASE SELECT ONE:

☐ Hospital 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.

☐ 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:
  a. 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
  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.

☐ Pregnancy [NOTE: An employee’s own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.] Any period of incapacity due to pregnancy, or for prenatal care.

☐ Chronic Conditions Requiring Treatment: a chronic condition which:
  a. Requires periodic visits for treatment by a health care provider, by a nurse or physician's assistant 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.).

☐ Permanent/Long-term Conditions Requiring Supervision: 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), kidney disease (dialysis).
**TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

1. Approximate date condition commenced:

2. Probable duration of condition:

3. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? **YES / NO** (circle one)

4. After review of the employee’s statement (see Section I), does the condition warrant the participation of the employee? **YES / NO** (circle one)

**FOR CONTINUOUS MEDICAL LEAVE**

5. Will the patient be incapacitated for a continuous period of time due to their medical condition, including any time for treatment and recovery? **YES / NO** (circle one)

   If **YES**, estimate the: Begin Date: _______________________ and End Date: ______________________

6. Estimate the period of time care needed or during which the employee’s presence would be beneficial:

   Begin Date: _______________________ and End Date: ______________________

**FOR PARTIAL/REDUCED SCHEDULE MEDICAL LEAVE**

7. Is it medically necessary that the employee work on a part-time or on a reduced schedule because of the patient’s medical condition? **YES / NO** (circle one)

   If **YES**, estimate the **part-time or reduced** work schedule the employee needs, if any:

   ______ hour(s) per day; ________ days per week

   Begin Date: _______________________ and End Date: ______________________

**FOR INTERMITTENT MEDICAL LEAVE**

8. Will the patient require the employee’s care on an intermittent or reduced schedule basis, including any time for recovery? **YES / NO** (circle one)

   If **YES**, 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 12 months (e.g., 1 episode per 3 months for 1-2 days):

   Frequency: ________ times per ________ week(s) OR ________ month(s)

   Duration: ________ hours OR ________ day(s) per episode

   Begin Date: _______________________ and End Date: ______________________

**TREATMENTS AND/OR APPOINTMENTS**

9. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? **YES / NO** (circle one)

10. Will the patient need treatment visits at least twice per year due to this condition? **YES / NO** (circle one)

11. Is it medically necessary that the employee be absent from work for treatment and/or appointments? **YES / NO** (circle one)

   If **YES**, **estimate** treatment schedule, **including** the dates of any scheduled appointments and the time required for each appointment (including travel time), including any recovery period:

**SIGNATURES**

__________________________________________  _____________________
Signature of Employee Date

__________________________________________  _____________________
Signature of Health Care Provider Date

*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 form is to be returned to the Benefits Office in University Hall room 165 participation; faxes are also accepted to (818) 677-7270. Questions may be directed to the Leave of Absence Specialist at (818) 677-3351.