



**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 permits an employer to require that an employee seeking FML protections because of 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 benefits of FML protections. You must return this completed form within 15 days of your request. Failure to provide a complete and sufficient medical certification may result in a denial of your FML request.

**Section I. For Completion by the Employee**

**Employee Instructions:**

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

Employee Name:	Employee ID:	Personal Phone Number:
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Current Mailing Address (Street, City, State & Zip):

Department:	Employee Classification:	Campus Phone Number:
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Name of family member for whom you will provide care (if applicable):

Family member relationship (if applicable):

I authorize the health care provider to complete this form and provide this information requested by San Francisco State University.  
**NOTE:** The information sought on this form pertains **only** to the condition for which the employee is requesting leave from work.

<b>Employee Signature</b>	<b>Date</b>
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**Section II. For completion by the Health Care Provider**

**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. Please do not disclose the underlying diagnosis without the consent of your patient. Limit your responses to the condition for which the employee or patient needs leave. Please complete Sections II through Sections V and be sure to sign the form on the last page.

Provider Name (You may attach a business card in lieu off completing this section)

Business Address	City	State	Zip Code
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Type of Practice / Medical Specialty

Telephone	Fax
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**Section III. Medical Facts**

1. Approximate date condition commenced: \_\_\_\_\_ Probably duration: \_\_\_\_\_

Dates you treated the patient for condition: \_\_\_\_\_

2. Page 4 is a description of what constitutes a "serious health condition" under both federal Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA). Does the patient's condition qualify under the categories described?

Yes  No

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:

\_\_\_\_\_

**Section IV. (For Employee Illness only) Mark all that apply**

1. Is the patient unable to perform any of the job functions due to his/her medical condition? (if "No," skip next question.)

Yes  No

If yes, identify the job functions the employee is unable to perform, work restrictions and probable duration:

2. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

Yes  No

If yes, state the frequency and expected duration of such treatment(s):

3. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  Yes  No

Beginning date: \_\_\_\_\_ Ending date: \_\_\_\_\_ Anticipated return to work date: \_\_\_\_\_

4. Will the patient be incapacitated on an intermittent or reduced schedule basis, including any time for recovery?

Yes  No

If yes, estimate intermittent or reduced schedule the employee needs:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week, from \_\_\_\_\_ through \_\_\_\_\_

Workload reduction (Faculty) \_\_\_\_\_%

5. Will the patient require follow-up treatment, including any recovery time?  Yes  No

If yes, estimate the schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period.

6. Will the condition cause episodic flare-ups periodically preventing the patient from performing his/her job functions?

Yes  No

Is it medically necessary for the employee to be absent from work during the flare-ups?  Yes  No

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

**Section V. (For 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?

Yes  No

Beginning date: \_\_\_\_\_ Ending date: \_\_\_\_\_ Anticipated return to work date: \_\_\_\_\_

2. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  Yes  No

If 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?

Yes  No

Does the patient require care during these flare-ups?  Yes  No

If yes, explain the care needed by the patient, and why such care is medically necessary:

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

Signature below verifies that the information provided above is true and accurate.

\_\_\_\_\_  
**Health Care Provider Signature**

\_\_\_\_\_  
**Date**

Rev 8/2017



**Definition of a Serious Health Condition**

For the purpose of FML, "serious health condition" means illness, injury, impairment, physical or mental condition that involves one of the following:

**1. Hospital Care**

Inpatient care 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. A person is considered an "inpatient" when a health care facility formally admits him or her to the facility with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such a person can be discharged or transferred to another facility and does not actually remain overnight.

**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 (including any subsequent treatment or period of incapacity relating to the same condition), that 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 by 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.

**3. Pregnancy**

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

*An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.*

**4. Chronic Conditions Requiring Treatment**

A chronic condition, 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 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:

- 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), or kidney disease (dialysis).

**Definition of Health Care Provider**

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as a

- 1. Doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker, physician's assistant, who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.
- 2. A health care provider also is any provider from whom the University or the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.