

**REQUEST/NOTIFICATION FORM
FAMILY CARE LEAVE, AND FMLA/CFRA ENTITLEMENTS
FOR EMPLOYEE'S OWN SERIOUS HEALTH CONDITION**

Name: _____ Employee ID #: _____

Mail Location: _____ Work Phone: (____) _____ Home Phone: (____) _____

Supervisor Name: _____ Work Phone: (____) _____

Requested leave from: _____ To: _____ Intermittent: Yes/No
(If time will be intermittent, list date(s) of employee's first occurrence)

Reason for leave (check one and explain)

- _____ A. Birth of employee's child/subsequent care of newborn
- _____ B. Placement of a son or daughter with employee in connection with adoption or foster care
- _____ C. Care of a spouse/spousal equivalent, son/daughter, or parent with a serious health condition.
(Medical certification is required)
- _____ D. Employee's own serious health condition - limited to 12 weeks per calendar year.
(Attach Medical Certification)

Explain briefly the reason for the leave request:

REPRESENTED EMPLOYEES ONLY

*If A Family Care Leave request is for more than 10 consecutive days, all unpaid vacation will be paid.
*Does not apply to leave for Employee's own serious Health Condition.

Does your leave request involve one of the following? _____ Intermittent absences _____ Reduced work schedule

My leave request is intermittent or a reduced work schedule and I am requesting use of the following hours in conjunction with my leave request:

_____ # of vacation hours _____ # of holiday credit hours _____ # of personal business allowance hours

Have you had any other family care leave in the past two years?

Yes _____ No _____ If Yes, List Dates: _____

Have you had any time away from work for your own serious health conditions in the past two years?

Yes _____ No _____ If Yes, List Dates: _____

Employee Signature _____ Date: _____

ACTION BY SUPERVISOR:

- Approved Family Care Leave
- Approved FMLA/CFRA leave
- Not Approved
- Approved pending Medical Certification Note: Medical Certification must be received within 15 calendar days of request for leave

Supervisor Signature: _____
Print Signature Date

ROUTING INSTRUCTIONS FOR:

Supervisor - Copy to Employee, Original to HR Advisor
HR - Original to Employee File; Copy to Employee Benefits, Payroll, Disability Management Services

**MEDICAL CERTIFICATION OF HEALTH CARE PROVIDER
FOR
FAMILY MEDICAL LEAVE ACT AND CALIFORNIA FAMILY RIGHTS ACT**

1. Employee's Name: _____

2. Patient's Name (If other than employee): _____

3. Date medical condition or need for treatment commenced [NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT]

4. Probable duration of medical condition or need for treatment

From: _____ To: _____

(provide dates employee must be absent from work)

5. The attached sheet 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). Does the patient's condition qualify under any of the categories described? If so, please check the appropriate category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____

6. If the certification is for the **serious health condition of the employee**, please answer the following:

Yes No

Is employee able to perform work of any kind? (If "No", skip next question.)

Is employee unable to perform any one or more of the essential functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

7. If the certification is for the **care of the employee's family member**, please answer the following:

Yes No

Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

After review of the employee's signed statement (See Item 10 below), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)?

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

9. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule.

Yes	No	Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member'?
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If the answer to 9. is yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider _____

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE

10. 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:

11. Signature of Employee:

Date: _____

12. Name of health care provider:

(signature of health care provider)

Address: _____

Date: _____ Telephone (____) _____

Important Note: Medical Certification from the health care provider must be included

Medical Certification Attachment

A "**Serious Health Condition**" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. 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.

2. Absence Plus Treatment

(a) 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:

- 1) 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
- (2) 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 [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.

4. Chronic Conditions Requiring Treatment

A chronic condition which:

- (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
- (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (3) 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, 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.

Medical Certification Attachment

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery there from) 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).