

Family Serious Health Condition

This Family Serious Health Condition leaves packet applies ONLY for faculty in the following Health Sciences Compensation Plan titles:

Assistant/Associate/Full Professor (Ladder)

Title codes: 001717, 001719, 001721

ASST PROF-HCOMP

ASSOC PROF-HCOMP

PROF-HCOMP

Assistant/Associate/Full Professor In Residence

Title codes: 001724, 001725, 001726

ASST PROF IN RES-HCOMP

ASSOC PROF IN RES-HCOMP

PROF IN RES-HCOMP

Assistant/Associate/Full Professor of Clinical X

Title Codes: 001455, 001454, 001453

ASST PROF OF CLIN-HCOMP

ASSOC PROF OF CLIN-HCOMP

PROF OF CLIN-HCOMP

Instructor/Assistant/Associate/Full Health Sciences Clinical Professor

Title Codes: 001731, 001732, 001733, 001734

HS CLIN INSTR-HCOMP (SON only)

HS ASST CLIN PROF-HCOMP

HS ASSOC CLIN PROF-HCOMP

HS CLIN PROF-HCOMP

Assistant/Associate/Full Adjunct Professor

Title Codes: 001728, 001729, 001730

ASST ADJ PROF-HCOMP

ASSOC ADJ PROF-HCOMP

ADJ PROF-HCOMP

Note: These are the primary UC Davis Schools of Health title/title codes used. For a full list of Health Sciences Compensation Plan membership eligible titles, please review

[APM 670-14.a.](#)

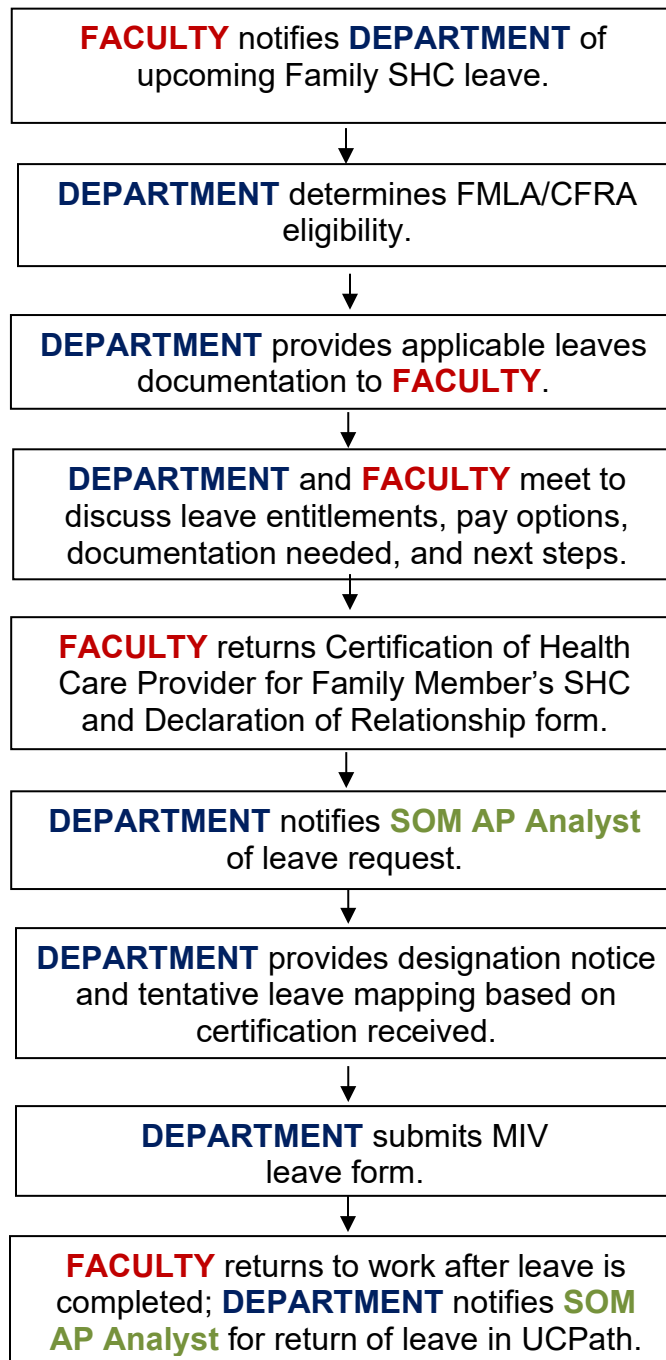
*If you are not a member of the Health Sciences Compensation Plan as defined in [APM 670](#), appointed in a corresponding title/title code, please return to our website to choose the appropriate packet for your title/title code. If you are unsure of your title, click here:

[Where to find your title in UC Path](#)

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Family Serious Health Condition (SHC) Leave Process



The following forms and documentation apply to Family Serious Health Condition (SHC) leaves for academic faculty titles.

- **[Notice of Eligibility and Rights and Obligations Form](#) (DEPARTMENT)**

When an employee first requests a leave for a reason that may qualify for FMLA leave/CFRA, or the department receives information of a possible qualifying event, the employer must notify the employee whether they are eligible for FMLA/CFRA leave. If the employee is eligible, the employer must notify the employee in writing about employee rights and responsibilities under the FMLA.

The Notice of Eligibility and Rights and Obligations Form should be provided to the employee **within five (5) days** of the department learning of a possible qualifying event or receipt of the leave request from the employee.

- **[Certification of Health Care Provider for Family Member's Serious Health Condition Form](#) (FACULTY)**

Medical certification to support employee's request for leave to care for a family member with a serious health condition. Providing this completed form is required to obtain (or retain) the benefit of FMLA/CFRA protections for the employee's leave.

The Certification of Health Care Provider for Family Member's Serious Health Condition Form should be provided to the employer **within fifteen (15) days** of receipt of the Notice of Eligibility and Rights and Obligations Form.

- **[Declaration of Relationship Form](#)**

This form should be completed by the employee when the employee requests FML to care for a family member with a serious health condition. Please note: This declaration is for FML purposes only and does not establish benefits eligibility for the family member.

The Certification of Health Care Provider for Family Member's Serious Health Condition and Declaration of Relationship Form should be provided to the employer **within fifteen (15) days** of receipt of the Notice of Eligibility and Rights and Obligations Form.

- **[Designation Notice Form](#) (DEPARTMENT)**

Once the employer has enough information to know whether a leave request qualifies as FMLA/CFRA leave, the employer must notify the employee in writing whether the employee's time off from work will be designated FMLA/CFRA leave, and the amount of time that will count against the employee's entitlements.

The Designation Notice Form should be provided to the employee **within five (5) days** of the employer receiving sufficient information regarding qualification of leave.

- **[Family Serious Health Condition Leaves Map](#) (DEPARTMENT)**

A leave mapping offers the employer and employee a full picture glance of leave entitlements, pay, and anticipated length of leave.

- **[Family and Medical Leave Benefits Fact Sheet](#)**

This University of California fact sheet offers general guidance on how Family and Medical Leave works, eligibility requirements, how to arrange for a leave, what happens to your benefits during a leave and how to make the transition back to work.

MEDICAL, DENTAL, AND VISION BENEFITS

If you are on UC pay status, all UC-sponsored benefits continue.

If you are off UC pay status and on one of these types of approved leaves, UC contributions for your medical, dental and vision will continue: Family and Medical (FMLA) and/or California Family Rights Act (CFRA) leaves. However, you may be responsible to pay your contribution for your medical benefits. Please see [UC's Leave Without Pay Fact Sheet](#) for more information.

CONTACT INFORMATION

UC Davis Health Benefits: benefits@ucdavis.edu (UC Davis Health or Campus)

Resources:

[Academic Personnel Manual Leave Policies](#)

[School of Medicine Academic Leaves Page](#)

[Academic Affairs Leave Page](#)

[University of California, Guide to UC Disability Benefits](#)

[MIV Leave Form Entry Job Aid](#)

[Catastrophic Leave Sharing Program](#)

Tools:

[FMLA/CFRA Eligibility Spreadsheet](#)

[Leaves Calculator](#)

This checklist should help you stay organized and ensure that you're taking the necessary steps for your leave of absence.

THREE MONTHS PRIOR TO LEAVE:

- Have you notified your department of a family serious health condition leave needed?**
- Has the department provided you with the following documents within five days of receiving notice of your leave?**
 - Notice of Eligibility and Rights and Obligations Form
 - Certification of Health Care Provider Form
 - University of California Family and Medical Leave Fact Sheet
- Have you met with your department AP analyst to discuss leave entitlements and pay options?**
 - Possible leave entitlements – [FMLA](#) / [CFRA](#) (it is recommended to familiarize yourself with these federal and state entitlements prior to meeting)
 - Possible pay entitlements – applicable Health Sciences Compensation Plan member benefit Sick Leave, PFCB, Vacation, Leave Without Pay
 - Department will also provide initial leave mapping based on leaves dates discussed

TWO MONTHS PRIOR TO LEAVE:

- Have you provided your department with a completed Certification of Health Care Provider for Family Serious Health Condition form and Declaration of Relationship form?**
- Has the department provided you with the following documents within five days of receiving sufficient information regarding qualification for leave?**
 - Provides Designation Notice
 - Provides updated leave mapping if needed, based on medical certification received

ONE MONTH PRIOR TO LEAVE:

- Have you discussed/finalized your proposed leave schedule with your department AP analyst and notified them of any changes/updates from your initial leave request?**
 - If yes, please provide the necessary documentation for these changes.
- Have you signed off your department's submitted My Info Vault (MIV) leave form(s)?**
 - Definition: MyInfoVault is an online database that houses academic personnel research, creative activity, teaching, and service data, and creates and routes electronic dossiers for academic peer review. It also allows for the creation and routing of academic leave of absence requests
 - Department drafts and submits MIV leave form for review/approvals
 - Faculty signs off on department-submitted MIV leave form(s)

WHEN YOU GO OUT ON LEAVE:

Keep in touch with your department AP analyst to inform them of any changes in your approved leave schedule.

- Provide updated family member's medical paperwork to the department if their disability dates that require care are different from the original anticipated disability dates provided earlier in the process.
- Note, accurate disability dates are important to ensure you receive the most comprehensive leave possible.

WHEN YOU RETURN TO WORK:

Check in with your department AP analyst on the first day back to “sign in”, so they can ensure you are returned from leave in UC Path.

Contact the Benefits Office

- Call Benefits to verify that all enrollments remain active

Contact information for Benefits:

benefits@ucdavis.edu

Main Phone: 530-752-1774 (voicemail only - for those without email)

Email (strongly preferred). Please include your phone number and UCPath ID

The following checklist is intended to help you stay organized and ensure that you are taking the necessary steps for your faculty's leave of absence. The SHORT checklist is helpful for quick reminders of next steps. The DETAILED checklist asks the same questions as the short checklist but provides additional guidance on what is needed for each step.

SHORT

- Did the employee request leave, or did the department learn of a possible qualifying event for the employee, for one of the following reasons?
- Is the employee eligible for FMLA leave?
- Has the department provided the necessary documents to the employee within five (5) days of receipt of leave?
- Has the department and employee meet to discuss leave entitlements and pay options?
- Has the department received the applicable Certification Form within fifteen (15) days of issuance of Notice of Eligibility and Rights and Obligations form?
- Has the department notified their SOM AP analyst of the leave request?
- Has the department provided the necessary documents within five (5) days of employer receiving sufficient information regarding qualification of leave?
- Has the department submitted the leave request in MIV?
- Does the department need to track this leave?
- Has the employee notified the department of any changes/updates from their initial leave request?
- Is the employee's leave ending soon?
- Has the department maintained employee's confidential leave documentation as a separate file from the employee's personnel file?

DETAILED

Did the employee request leave, or did the department learn of a possible qualifying event for the employee, for one of the following reasons?

- Employee's own serious health condition
- Serious health condition of spouse, domestic partner, child, parent, parent-in-law, grandparent, grandchild, sibling
- Birth, adoption, or foster placement of child
- Military "qualifying exigency"
- Serious Injury or illness of a covered service member

Is the employee eligible for FMLA leave?

- Has the employee worked at least 12 months for the company (need not be consecutive)?
- Has the employee worked at least 1,250 hours in the preceding 12 calendar months?
 - Hours actually worked include overtime but do not include holiday, vacation, sick leave, or other paid leaves.
- Has the employee already used FMLA leave this calendar year? If so, do they still have FMLA leave available?
- If not FMLA/CFRA eligible, does the employee have other leave options?

Has the department provided the following documents to the employee within five (5) days of receipt of leave?

- Notice of Eligibility and Rights and Obligations Form
- Declaration of Relationship Form
- University of California Family and Medical Fact Sheet

Has the department and employee met to discuss leave entitlements and pay options?

- Leave entitlements – FMLA / CFRA
- Pay options – applicable Health Sciences Compensation Plan member benefit Sick Leave, PFCB, Vacation, Leave Without Pay
- Provide initial mapping of leave based on desired dates provided by employee

Has the department received the Declaration of Relationship form and the applicable Certification Form within fifteen (15) days of issuance of Notice of Eligibility and Rights and Obligations form?

- Have you reviewed the form for completeness?
 - For incomplete certification or if clarification is needed, retain a copy and return original certification to the employee with explanation of deficiencies and request new certification to be submitted within seven days.
- Is the leave for a qualifying reason?

Has the department notified their SOM AP analyst of the leave request?

- Sends an email to their assigned SOM AP analyst advising of the forthcoming MIV leave request and provides a copy of the medical certification received.

Has the department provided the following documents within five (5) days of employer receiving sufficient information regarding qualification of leave?

- Provides Designation Notice to employee
- Provides Return to Work Certification
- Provides updated leave mapping if needed, based on medical certification received.
- If intermittent leave, advise employee's manager/supervisor of approved time away due to FMLA leave.

Has the department submitted the leave request in MIV?

- Drafts and submits MIV leave form for review/approvals
- Sends corresponding leave documentation to their dean's office AP analyst for review of the employee's completed MIV leave request

Does the department need to track this leave?

- Departments should track intermittent leave usage.

Has the employee notified the department of any changes/updates from their initial leave request?

- If yes, has the employee provided the necessary documentation for these changes?
- Does the department need to update the existing leave form in MIV for proper leaves tracking?
- Has the department notified appropriate personnel of these changes, if needed?

Is the employee's leave ending soon?

- Send an email 1-2 weeks in advance of anticipated leave end date to check in with the employee to:
 - Confirm return date or possible leave extension.

Has the department maintained employee's confidential medical leave documentation as a separate file from the employee's personnel file?

- Leave records should be maintained for 3 years.

Frequently Asked Questions

Q: How do I request a Family Member’s Serious Health Condition leave?

A: Contact your supervisor and department analyst so they can provide information on your eligibility and options.

Q: What is the difference between leave entitlement and paid leave benefits?

A: Leave entitlements describe the types of “protected” leave to which you are entitled under University policy (incorporating federal and state laws, including PDLL, FMLA, CRFA, etc.). Income replacement, or paid leave benefits, describes the policies and procedures under University policy whereby you can continue to receive income notwithstanding that you are not working (i.e., on leave).

Q: How does the new APM-710 faculty sick leave entitlement affect my previous 5-day comp plan leave benefit?

A: UC Davis Health Sciences Compensation Plan faculty have had five days of sick leave which could only be used to care for family members. The change to APM-710 will be incorporated into the Comp Plan, increasing both the amount of leave available (six days instead of five) and broadening the scope so you may use this leave either for your own illness or to care for a family member. Also, this leave is “protected,” meaning the University cannot take an adverse action against a faculty member who utilizes the leave appropriately.

Q: Am I required to use the Pay for Family Care and Bonding (PFCB) pay benefit when going out on an approved leave for a Family Member’s Serious Health Condition?

A: No, when you use PFCB pay benefit is up to you. If you would prefer to use your sick leave, accrued vacation, or take unpaid leave, that is totally your discretion.

Q: What if I have used all my 8 weeks of PFCB pay benefit and have an upcoming leave?

A: Your PFCB will no longer be available. This pay benefit is only available for eight workweeks per calendar year. If you have exhausted that pay benefit, you can look into other possible pay options such as your five annual compensation plan days, vacation pay, or leave without pay. Please reach out to your department analyst to start that conversation.

Q: Who should sign my medical documentation (e.g. disability certification, return to work certification, etc.)?

A: Medical documentation should be signed by your health care provider.

Under the FMLA, the definition of health care provider includes, but is not limited to the following: doctor of medicine or osteopathy, physician assistant, nurse practitioner, podiatrist, dentist, nurse-midwife, clinical psychologist, clinical social worker, optometrist, chiropractor, Christian Science practitioner, and any provider covered under the employer group health plans, including foreign countries. Other health care providers may be acceptable, please contact AP for guidance.

Q: How do I return to work after my leave?

A: Employees on leave due to a Family Member’s Serious Health Condition do not require a Return to Work form.

NOTICE OF ELIGIBILITY AND RIGHTS & RESPONSIBILITIES (R12/22)**Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), & California Pregnancy Disability Leave Law (PDLL)**

In general, to be eligible for Family and Medical Leave (FML), an employee must have worked for the University of California for at least 12 months and have worked at least 1,250 hours in the 12 months preceding the leave. These eligibility requirements do not apply to Pregnancy Disability Leave taken under PDLL.

Part A – NOTICE OF ELIGIBILITY

To: Joe Jones

August 15, 2025

Employee

Date

From: Fionna Fizzlepuff

University Representative

On August 14, 2025, you informed the University that you needed leave beginning on September 4, 2025 and with an anticipated end date of November 6, 2025 for:

- Your own serious health condition.
- The need to care for one of the following family members due to their serious health condition:
 spouse; domestic partner; designated person; child; parent; parent-in-law;
 grandparent; grandchild; sibling.
- Pregnancy Disability Leave (PDL). This leave may be used when you are disabled by pregnancy, childbirth, or a related medical condition. It may also be used for prenatal care.
- Parental bonding leave following the birth of a child, or placement of a child with you for adoption or foster care.
- Military caregiver leave to care for a family member who is a Covered Servicemember with a serious injury or illness. You are the Covered Servicemember's:
 spouse; domestic partner; child; parent; next of kin.
- A qualifying exigency related to the following family member's active duty or call to active duty status with the Armed Forces:
 spouse; domestic partner; child; parent; parent-in-law.

This Notice is to inform you that:

- You are eligible for FML and have FML entitlement remaining and available to use for the applicable period under the following statute(s): FMLA; CFRA; PDLL. (See Part B below for Rights and Responsibilities.)
- You are eligible for FML but you have already exhausted the applicable FML leave entitlement for the applicable period.

You are **not** eligible for FML under FMLA and/or CFRA because:

- You have not met the 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.
- You have not met the 1,250-hours-worked requirement.

If you have any questions, contact Fionna Fizzlepuff or view the

FMLA, CFRA, and/or PDLL posters located in your home department and online, as well as applicable policies and/or collective bargaining agreement provisions.

Part B – RIGHTS AND RESPONSIBILITIES FOR TAKING FML (To be completed only if the employee is eligible and has not exhausted the applicable leave entitlement.)

As explained in Part A, you meet the eligibility requirements for taking FML and still have FML leave entitlement available in the applicable period. **However, in order for us to determine whether your absence qualifies as FML, you should return the following information to us by** August 30, 2025. When certification is requested, employees have at least 15 calendar days from receipt of this notice to provide it. Under certain circumstances, additional time may be provided. If sufficient information is not provided in a timely manner, your leave may be denied.

- Sufficient certification to support your request for FML. A certification form that sets forth the information necessary to support your request is enclosed.
- Sufficient documentation to establish the required relationship between you and your family member. The required declaration form is enclosed.
- Other information needed: _____

If your leave does qualify as FML, you will have the following **responsibilities** while on leave (only checked boxes apply):

- Contact UC Path at 855-982-7284 to make arrangements to either (a) maintain your health benefits during your leave by continuing to make your share of the premium payments or (b) opt out of your health benefits during your leave. You have a minimum of 30 days to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during your FML, and recover these payments from you upon your return to work.
- You will be required to use the following paid leave during your FML absence: your available **sick leave**, **vacation**, and/or **other leave**. Your entire FML absence, including any period during which you are using paid leave, will be counted against your FML leave entitlement. **Note:** This requirement to use paid leave does not apply to any part of an FML absence during which employees are using Pay for Family Care and Bonding (PFCB).
- While on leave you will be required to furnish us with periodic updates of your status and intent to return to work every: _____ *[Indicate interval of periodic updates, as appropriate for the particular leave situation].*
- If the circumstances of your leave change, and you are able to return to work earlier than the date indicated in Part A of this form, you need to notify your supervisor at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FML, you will have the following **rights** while on leave:

- You have a right under the FMLA and/or the CFRA for up to 12 workweeks of unpaid leave in the calendar year (January-December) if you are taking leave for any FML qualifying purpose other than Military Caregiver Leave.
- You have a right under the FMLA for up to 26 workweeks of unpaid leave in a single 12-month period to care for a Covered Servicemember with a serious injury or illness (Military Caregiver Leave). This single 12-month period commenced or will commence on: _____.
- You have a right under the PDLL for up to four months of unpaid leave per pregnancy.
- Your FML leave will be designated and counted against your applicable statutory FML leave entitlement(s) and will be job-protected leave as required under the applicable statute.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- If you return directly from a leave under the PDLL, you will be reinstated to the same position or, if the same position is not available, to a comparable position. (If your leave extends beyond the end of your FML leave entitlement(s), you do not have statutory return rights.)
- If you return directly from any statutory FML leave other than a leave under the PDLL, you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your

return from FMLA-protected and/or CFRA-protected leave. (If your leave extends beyond the end of your FML leave entitlement(s), you do not have statutory return rights.)

- You may be required to reimburse the University for its share of health insurance premiums paid on your behalf during any unpaid portion of your FML if you do not return to work following FML for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition that would entitle you to FML; 2) the continuation, recurrence, or onset of a Covered Servicemember's serious injury or illness which would entitle you to FML; or 3) other circumstances beyond your control.
- If we have not informed you above that you must use paid leave while taking your unpaid FML leave entitlement, you may have the right under the applicable policy or collective bargaining agreement to use Pay for Family Care and Bonding (PFCB) and/or the following paid leave during your FML absence: **sick leave, vacation leave, and/or other leave**. Applicable conditions related to the use of PFCB and paid leaves are referenced or set forth below. If you do not meet the requirements for using PFCB and/or paid leave, you remain entitled to take unpaid FML leave. Your entire FML absence, including any period during which you are using PFCB or paid leave, will be counted against your FML leave entitlement.

For conditions applicable to PFCB and sick/vacation/other leave usage please refer to _____ available at: _____

Applicable conditions for use of paid leave: _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FML and count towards your FML leave entitlement. Meanwhile, WE HAVE PROVISIONALLY DESIGNATED YOUR LEAVE AS FML. If you have any questions, please do not hesitate to contact: Fionna Fizzlepuff at 916-554-5551, ffizzlepuff@ucdavis.edu

DEPARTMENT SIGNATURE

NAME (PRINT)

Fionna Fizzlepuff

SIGNATURE

Fionna Fizzlepuff

DATE

8/15/25

Print Form

**CERTIFICATION OF HEALTH CARE PROVIDER
FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION (R12/22)
Family and Medical Leave Act ("FMLA") & California Family Rights Act ("CFRA")**

PURPOSE of FORM: The below-named employee of the University of California has requested a leave of absence to care for a family member with a health condition, which may qualify as a protected leave under the FMLA and/or CFRA. Employees may take such leave to care for their spouse, domestic partner, designated person, child (including the child of the employee's domestic partner), parent, parent-in-law, grandparent, grandchild, or sibling. This medical certification form will provide the University with information needed to determine if the employee's requested leave is for a qualifying reason under the FMLA and/or CFRA. Section III must be fully completed by the health care provider.

INSTRUCTIONS to EMPLOYEE: Please complete and sign Section II before giving this form to your family member or your family member's health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA and/or CFRA leave due to your family member's serious health condition. Providing this completed form is required to obtain (or retain) the benefit of FMLA and/or CFRA protections for your leave. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days of the University's request for this information, or no later than August 30, 2025.

If you cannot return the completed form within the stated deadline, please contact Fionna Fizzlepuff with the reasons for the delay and the date when the certification will be provided. You may return the form in person, by mail, or by fax. The fax number is 916-554-5552.

You should include a fax cover sheet marked "**CONFIDENTIAL**" and address your fax to:

"ATTENTION: Fionna Fizzlepuff"

SECTION I: To be completed by THE UNIVERSITY

Employee's Name

Joe Jones

Name of University Representative

Fiona Fizzlepuff

University Representative Department Address
1112 UC Davis Avenue, Sacramento, CA 95817

Telephone 916-554-5551

SECTION II – To be completed by EMPLOYEE

Name of family member for whom you will provide care:

Betty Jones

If family member is your child, date of birth:

Relationship of family member to you: Spouse

If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability? No Yes

Describe care you will provide to your family member and estimate the duration of leave needed to provide care.
Assisting with mobility, administering medication, attending medical appointments, and helping with daily living activities.

Are you requesting leave on an intermittent or reduced schedule basis? No Yes

If yes, please describe the leave schedule you are requesting:

SIGNATURE

EMPLOYEE SIGNATURE

Joe Jones

DATE 8/15/2025

SECTION III – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA and/or CFRA to care for your patient. Please 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 “indefinite,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA/CFRA coverage. **Limit your responses to the condition for which the patient needs the employee’s care.** Please be sure to sign and date the form on Page 3.

IMPORTANT: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSIS WITHOUT THE PATIENT’S CONSENT.

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 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 assistive reproductive services.

THE CALIFORNIA GENETIC INFORMATION NONDISCRIMINATION ACT OF 2011 (CaGINA): The California Genetic Information Nondiscrimination Act of 2011 (CaGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with CaGINA, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic Information,” as defined by CaGINA, includes information about the individual’s or the individual’s family member’s genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. “Genetic Information” does not include information about an individual’s sex or age.

PROVIDER’S NAME

Dr. Ann T. Biotic

BUSINESS ADDRESS

1234 X Street, Sacramento, CA 95817

TELEPHONE

916-553-5550

FAX

916-553-5551

PART A: MEDICAL FACTS

(1) Approximate date condition commenced:

8/1/25

Probable duration of condition:

From: 8/1/25 To: 11/15/25

(2) Page 4 describes what is meant by a “[serious health condition](#)” under both the FMLA and CFRA. Does the patient’s condition qualify under any of the categories described? No Yes

If yes, which type of [serious health condition](#) listed on Page 4 applies:

1 2 3 4 5 6

PART B: AMOUNT OF CARE NEEDED

When answering these questions, keep in mind that your patient’s need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

(1) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? No Yes

Estimate the beginning and ending dates for the period of incapacity:

9/4/25-11/6/25

During this time, does the patient’s condition warrant the participation of the employee? (In answering this question, please review the employee’s statement of care in Section II, page 1.) No Yes

(2) If the employee has requested leave on an intermittent or reduced schedule leave basis (see answer in Section II, page 1, question 2), is it medically necessary for the patient to receive care on an intermittent or reduced schedule basis, including any time for recovery? No Yes

If yes, estimate the hours the patient needs care from the employee:

Hours per Day _____	Days per Week: _____	From: _____	Through: _____
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SIGNATURE

Signature of HEALTH CARE PROVIDER <i>Ann T. Biotic, M.D.</i>	Date 8/22/25
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Print Form

Serious Health Conditions

A “serious health condition” means an illness, injury (including, but not limited to, an on-the-job injury), impairment, or physical or mental condition that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse.

- Inpatient Care means a stay in a hospital, hospice, or residential health care facility, any subsequent treatment in connection with such inpatient care, or any period of incapacity. A person is considered an inpatient when a health care facility formally admits them to the facility with the expectation that they will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.
- Incapacity means the inability to work, attend school, or perform other regular daily activities due to a serious health condition, its treatment, or the recovery that it requires.
- Continuing Treatment means ongoing medical treatment or supervision by a health care provider.

A serious health condition involves one or more of the following:

1. Inpatient Care (as defined above)

2. Absence Plus Treatment

A period of incapacity of more than three (3) 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 (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

3. Pregnancy (which is covered as a serious health condition under FMLA but not under CFRA)

A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.

4. Chronic Conditions Requiring Treatment

A chronic condition that:

- (a) 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;
- (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 person 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. 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 (3) 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).

- Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FML leave entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

If more than one statute is checked above, please note:

- For an FML leave other than Pregnancy Disability Leave: If both the FMLA and CFRA boxes are checked above, you will be concurrently using your entitlements under those statutes until you have either completed your leave or exhausted one or both of those entitlements.
- For a Pregnancy Disability Leave (whether or not immediately followed by Parental Bonding Leave): During the first 12 workweeks of your Pregnancy Disability Leave, you will be concurrently using your PDLL and FMLA entitlements until you have either completed your Pregnancy Disability Leave or exhausted your FMLA entitlement. If your Pregnancy Disability Leave continues after that point, you will only be using your PDLL entitlement until you have either completed your Pregnancy Disability Leave or exhausted your PDLL entitlement. If you take Parental Bonding Leave immediately following Pregnancy Disability Leave and you have not yet exhausted both your FMLA and CFRA entitlements, you will be concurrently using your FMLA and CFRA entitlements during your Parental Bonding Leave until you have either completed your leave or exhausted one or both of those entitlements.

Please be advised (check if applicable):

- You have requested to use paid leave during your FML. Your entire FML absence, including any period during which you ²⁰ are using paid leave, will count against your FML leave entitlement.
- You have requested to use Pay for Family Care and Bonding (PFCB) during your FML. If your leave qualifies for the PFCB option and you have PFCB entitlement available, your entire FML absence, including any period during which you are using PFCB, will count against your FML leave entitlement.
- We are requiring you to use paid leave during some or all of your FML. Your entire FML absence, including any period during which you are using paid leave, will count against your FML leave entitlement.
- You will be required to provide the enclosed Return to Work certification to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. If the job description is attached, the Return to Work certification must address your ability to perform those essential functions that you were unable to perform as a result of your serious health condition.
- A job description listing the essential functions of your position is attached to the Return to Work Certification.

PART B: To Be Completed if FML Request Is Not Approved

Your FML request is **Not Approved** because:

- Your leave is not for an FML-qualifying reason.
- You have not provided the necessary information to support your request for FML.
- You have exhausted your FML leave entitlement for the applicable period.

DEPARTMENT SIGNATURE

NAME (PRINT)

Fionna Fizzlepuff

SIGNATURE

Fionna Fizzlepuff

DATE

8/22/25

ENTITLEMENTS:

SICK: 9/4/25 - 9/11/25

FMLA: 9/4/25 - 11/6/25 > FMLA/CFRA run concurrently

CFRA: 9/4/25 - 11/6/25

2025

PAY OPTIONS:

Family Serious Health Condition

Sick: 9/4/25-9/11/25, 6 days (full salary)

PFCB: 9/12/25-11/6/25, 8 weeks (base salary only)

January						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

September						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

October						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

November						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

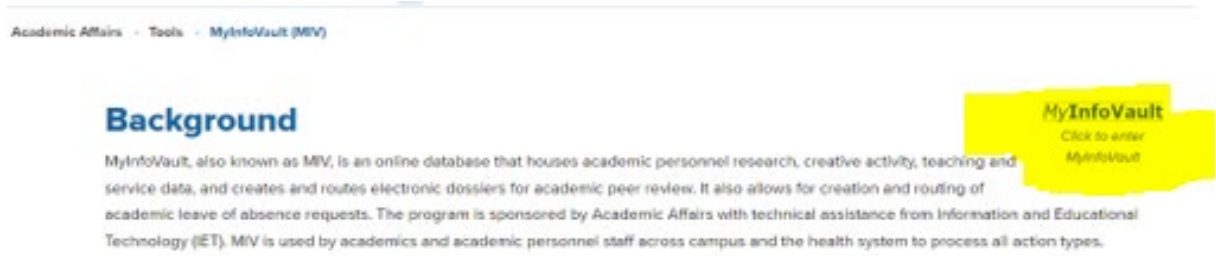
December						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Date out: September 4

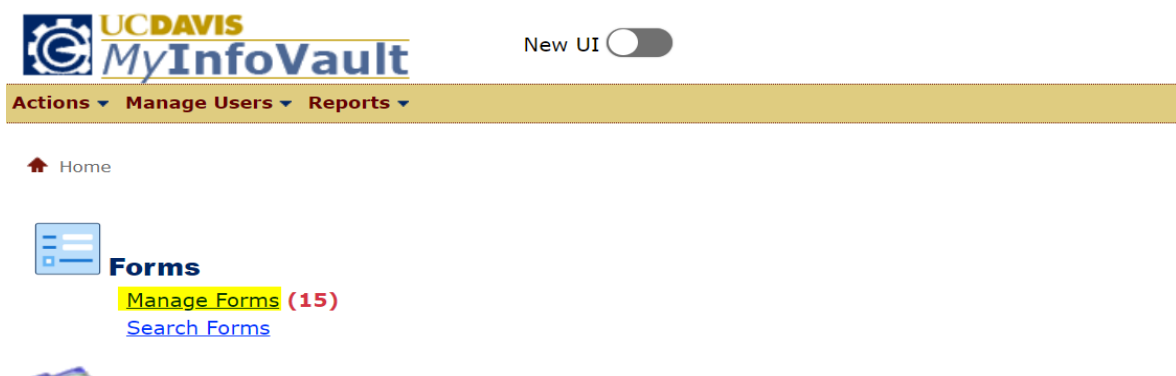
Return date: November 7

Instructions: How to submit an FMLA/CFRA eligible Family SHC leave form in MIV (one form)

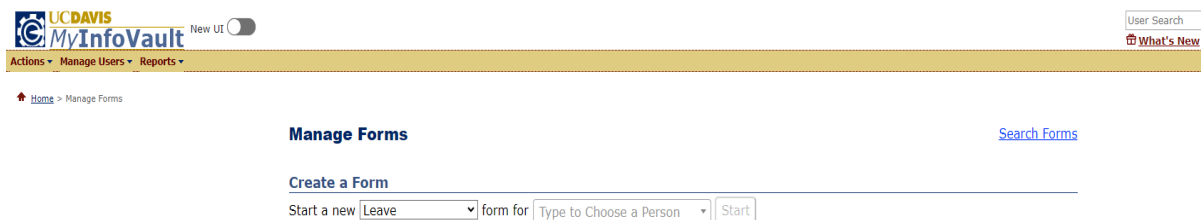
1. Log into My Info Vault (MIV), <https://myinfovault.ucdavis.edu>



2. Select "Manage Forms"



3. Start a new leave and select faculty's name and select start



4. Select type of leave "Family Medical" and leave type "Family Serious Health Condition (SHC)"

What kind of leave are you requesting?	Please select the leave type
<input type="text" value="Family Medical"/>	<input type="text" value="Family Serious Health Condition (SHC)"/>

5. Select designation as “FMLA/CFRA”

Select the designation for this leave

6. Select Paid or Unpaid option and Block or Intermittent/Reduced Schedule option

Will this be a Paid or Unpaid leave? as

7. Select whether faculty is part of the compensation plan

Is the applicant part of the medical school compensation plan?

8. Select Yes or No on whether faculty will receive other sources of income while on leave

Will you receive other sources of income while on leave?

9. Enter Pay Period Begin and End Date (leave dates), as well as Return Date

Pay Period Begin Date Pay Period End Date
Pay Period Return Date

10. Enter the Service Period Begin and End Date (should be the same as Pay Period dates)

Service Period Begin Date Service Period End Date

11. Select whether this request is an extension of a previous leave (usually no)

Is this an extension of a previous leave?


12. Enter "Family Serious Health Condition" as the specific purpose of the proposed leave

What is the reason for or specific purpose of proposed leave?

Do not include private health information covered under HIPAA, such as diagnoses, treatment plans, or FMLA forms.

13. Leave documentation is optional (Do not include medical certification completed by health care provided)

Please upload your Leave Documentation



Drag and drop a file here or click

14. Select Yes or No whether the faculty is a Principal Investigator

Are you a Principal Investigator?

15. If Yes, select whether a substitute will be selected

Is applicant a Principal Investigator?	Yes
Will a substitute be selected?	No

16. Fill in on how the faculty's work will be covered on leave. Usually "Clinical Gen Pool Coverage", or "Clinical coverage covered by colleagues"

How will your work be covered while you are on leave?

17. If applicable, include details on how faculty's classes will be distributed for coverage. Select N/A if not applicable

If leave is granted, how will the applicant's classes be distributed?

18. Select the box next to "Please Acknowledge"

I certify that the FMLA/CFRA/PDLL paperwork has been properly filed in the department.

Please Acknowledge

19. Please include a full breakdown of leave designations and dates in "Additional Comments"

Additional Comments

***Sample completed leave forms attached.**

Edit Leave

First name Last name

Employee ID: 10200000

What kind of leave are you requesting?

Family Medical

Please select the leave type

Family Serious Health Condition (SHC)

Select the designation for this leave

FMLA

CFRA

FMLA/CFRA

Will this be a Paid or Unpaid leave?

Paid

Unpaid

as

Block

Intermittent/Reduced Schedule

Is the pay full or partial salary?

Full

Partial

Is the applicant part of the medical school compensation plan?

Yes

No

Proposed salary distribution while on leave

The faculty member will receive the following pay during their leave:

Sick pay for full salary from 9/4/25-9/11/25

8 weeks PFCB pay for partial salary from 9/12-11/6/25 (Base pay only, X+X')

Will you receive other sources of income while on leave?

Yes

No

Pay Period Begin Date

09/04/2025

Pay Period End Date

11/06/2025

Pay Period Return Date

11/07/2025

Service Period Begin Date

09/04/2025

Service Period End Date

11/06/2025

Is this an extension of a previous leave?

Yes

No

What is the reason for or specific purpose of proposed leave?

Do not include private health information covered under HIPAA, such as diagnoses, treatment plans, or FMLA forms.

Family Serious Health Condition

Please upload your Leave Documentation



Drag and drop a file here or click

Are you a Principal Investigator? Yes No

How will your work be covered while you are on leave?

Clinical coverage covered by colleagues

If leave is granted, how will the applicant's classes be distributed?

N/A

I certify that the FMLA/CFRA/PDLL paperwork has been properly filed in the department.

Acknowledged by Fiona Fizzlepuff

Additional Comments

Save Draft

Exit Without Saving

Submit and Request Applicant Signature