Certification of Healthcare Provider for Family Serious Health Condition (NON - FML ELIGIBLE)

UC DAVIS HEALTH

PURPOSE: For employees requesting leave who did not qualify for, or have exhausted, Family and Medical Leave. 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. 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 employee's leave. Section III must be fully completed by the health care provider.

INSTRUCTIONS:

HEALTH CARE PROVIDER: **Please DO NOT disclose the employee's family member's underlying diagnosis.** Your patient (our employee's family member) has requested leave for their serious health condition. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the employee. Be as specific as possible; terms such as "indefinite," "unknown," or "indeterminate" *are not sufficient* to determine leave coverage. Limit your responses to the condition for which the employee is seeking medical leave. Be sure to sign and date the form.

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. Submit timely, complete, and sufficient medical documentation to support your request. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your requested leave.

Please complete form and have the employee return it, or fax it to the University Representative named herein.

SECTION I: To be completed by THE UNIVERSITY		
EMPLOYEE'S NAME		EMPLOYEE'S JOB TITLE
NAME OF UNIVESITY REPRESENTATIVE		MAILING ADDRESS OF UNIVERSITY REPRESENTATIVE
TELEPHONE	FAX	E-MAIL

SECTION II – To be completed by EMPLOYEE	
Name of family member for whom you will provide care:	
If family member is your child, date of birth:	Relationship of family member to you:
If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability? ☐ Yes ☐ No	
Describe care you will provide to your family member and estimate the duration of leave needed to provide care.	
Are you requesting leave on an intermittent or reduced schedule basis?	☐ Yes ☐ No
If yes, please describe the leave schedule you are requesting:	

SIGNATURE	
EMPLOYEE SIGNATURE	DATE

*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.

SECTION III – To be completed by HEALTH CARE PROVIDER	
PROVIDER'S NAME	BUSINESS ADDRESS
TELEPHONE	FAX

PART A: MEDICAL FACTS	
(1) Approximate date condition commended: _____	Probable duration of condition From: _____ To _____
(2) Page 3 describes what is meant by a "serious health condition". Does the patient's condition qualify under any of the categories described?	☐ Yes ☐ No
If yes, which type of serious health condition listed on Page 3 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?	☐ Yes ☐ No
Estimate the beginning and ending dates for the period of incapacity:	
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.)	☐ Yes ☐ No
(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?	☐ Yes ☐ No
If yes, estimate the hours the patient needs care from the employee:	

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

SIGNATURE	
Signature of HEALTH CARE PROVIDER	Date

Serious Health Conditions

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Inpatient 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. **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 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). Note: 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 (only if exhausted PDL and/or FMLA)**
   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 which:
   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 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. **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), or kidney disease (dialysis).