

City of Torrance
Physician or Practitioner Medical Certification for Medical Leave, FMLA/CFRA
Employee – Serious Health Condition

TO BE COMPLETED BY THE TREATING PHYSICIAN OR HEALTH CARE PROVIDER ONLY.

1. Employee's Name: _____
2. Does the employee have a "serious health condition" as described on the reverse of this form? If the employee's condition qualifies under any of these categories, please check the applicable number:
(1) (2) (3) (4) (5) (6) or none of the above .
3. Date medical condition or date for treatment commenced (NOTE: Health Care Provider has the discretion to disclose the underlying diagnosis):
_____ / _____ / _____
4. Probable duration of medical condition or need for treatment: _____

Check Yes or No in the box below, as appropriate:

- | | Yes | No | |
|----|--------------------------|--------------------------|--|
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Is inpatient hospitalization of the employee required? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Is employee able to perform work of any kind? (If "No", skip to item 10.) |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Is the medical condition pregnancy? If "Yes", expected delivery date: |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Is employee able to perform the functions of the employee's position? (Answer after reviewing the attached job description describing essential functions of employee's position, or, if none provided, after discussing with employee.) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Is this certification for an <u>ongoing leave that needs to be extended</u> (recertification)? If yes, please skip to question # 11. |

Note to Health Provider: Question 10 & 11 must be completed in order to process application for leave.

10. What date did you recommend the patient stop working? _____ / _____ / _____
11. What date will the patient be released to return to work? _____ / _____ / _____

Please answer questions 12 and 13 only if employee is asking for intermittent leave or a reduced work schedule.

- | | Yes | No | |
|-----|--------------------------|--------------------------|--|
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Is it medically necessary for the employee to be off work on an intermittent basis or on a reduced work schedule in order to deal with a serious health condition? |

If answer to 10 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 provider.

13. Date intermittent leave to begin: _____ / _____ / _____ Date intermittent leave to end: _____ / _____ / _____
14. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? Yes No

If Yes, is it medically necessary for the employee to be absent from work during the flare-ups? Yes No If yes, explain:

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 6 months (e.g., 1 episode every 3 months last 1-2 days)

Frequency: _____ times per: weeks month

Duration: _____ hours or day(s) per episode

ADDITIONAL INFORMATION:

Print Physician Name

Physician Signature

Specialty

Date

Address

Telephone

A “Serious Health Condition” under both the Federal and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) 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 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:

- (1) Treatment¹ two or more times by a health care provider, by a nurse or physician’s assistant under direct supervision of a healthcare provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider. These two visits to the health care provider must occur within 30 days of the beginning of the period of incapacity, and the first visit must take place within seven days of the first day of incapacity; or
- (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment² under the supervision of the health care provider. This visit must take place within the first seven days of the first day of incapacity.

3. Pregnancy

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

4. Chronic Conditions Requiring Treatment

A chronic condition which:

- (1) Requires periodic visits (at least two visits to a health care provider per year) for treatment by a health care provided, or by a nurse 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 must be under the counting 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 the 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), and kidney disease (Dialysis).

¹ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition.

Treatment does not include routine physical examinations, eye examinations, or dental examinations.

² A regimen of treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen or treatment does not include taking over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.