

CITY OF TORRANCE

CERTIFICATION OF HEALTH CARE PROVIDER EMPLOYEE'S OWN SERIOUS HEALTH CONDITION

Under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA) and/or applicable City Leave Policies

I. EMPLOYEE'S INFORMATION

_____ Employee's Name	_____ Employee's Date of Birth	_____ Employee Identification Number
_____ Employee's Department	_____ Employee's Job Title	_____ Employee's Regular Work Schedule

II. THE EMPLOYEE'S SERIOUS HEALTH CONDITION

A. Nature of the Serious Health Condition (Select One):

1. Inpatient Hospital Care
(an overnight stay in a hospital, hospice or residential care facility, including periods of incapacity associated with this stay)
2. Incapacity and Treatment
(treatment two or more times following a period of incapacity of more than three consecutive full calendar days)
3. Pregnancy, due date ___/___/___ actual estimated
(any period of incapacity due to a pregnancy or recovery from childbirth, including pre- and post-natal care)
4. Chronic Condition
(a period of incapacity or treatment for a condition requiring regular provider visits/treatment, and continuing for an extended time)
5. Permanent or Long-term Condition
(a period of incapacity or treatment due to a long-term condition under the continuing supervision of a provider)
6. Multiple Treatments for a Non-Chronic Condition
(a period of absence to receive multiple treatments for restorative surgery or a condition that would result in incapacity if not treated)
7. None of the Above – explain:

B. Medical Facts about the Serious Health Condition

(such as nature of incapacity, regimen of continuing treatment or follow-up appointments, etc. DO NOT INCLUDE DIAGNOSIS)

If chiropractor, is the treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray? Yes No

Is the employee able to perform work of any kind? If "NO" skip the next question.
 No Yes

Is the employee unable to perform any one or more of the essential functions of his/her position? Answer after reviewing statement from employer of essential functions, or if none provided, after discussing with the employee. No Yes

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III. REQUESTED TIME OFF WORK:

- A. Will the employee be incapacitated for a single continuous period of time, including time for treatment and recovery? No Yes – provide start and end dates, below:

Leave Start Date

Expected Leave End Date

Expected Return to work date*

- B. Will the employee need intermittent time off due to this serious health condition?
 No Yes – if Yes, are these absences medically necessary? No Yes, if so provide details below:

Intermittent Period
Start Date

Intermittent Period
End Date*

Frequency: _____ absences per month (maximum)

Duration: _____ hours per absence (maximum)

Will these absences be consecutive? No Yes

If yes, up to _____ days in a row.

*if period end date is not known, please provide an estimated date that re-evaluation will occur.

Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment including recovery period:

Dates of Appointments

Time Required Per Appointment

Recovery Period Required

- C. Will the employee need to work part-time or a reduced work schedule due to this serious health condition?
No Yes - if yes, is this schedule medically necessary? No Yes, if so provide details below:

_____ hours per work day _____ days per workweek

Reduced Schedule
Start Date

Reduced Schedule
End Date

IV. Limited Authorization for Release of Health Care Information

Employee's Name

Employee's Date of Birth

Patient's Name (if not Employee)

*I authorize the release of any medical information necessary to complete this form.
Knowingly providing false information directly, or through another party, may result in adverse action against the employee.*

Employee's Signature

Date

CERTIFICATION BY PROVIDER: *By signing below you are certifying that the information you have provided is accurate and complete, and that this information is based on your personal knowledge of the patient's condition.*

Providers Printed Name and Credentials

Type of Practice

Telephone Number

Providers's Office Address (Street, City, State, Zip Code)

Best times & Days to Call

Provider's Signature (No stamps or Proxy Seals Accepted)

Date