



SEND DIRECTLY TO: Return to Work Coordinator
City of San José – Human Resources
200 E. Santa Clara St., 2nd Floor Wing
San Jose, CA 95113-1905
Ph. (408) 535-1285
Fax (408) 292-6447

Medical Verification

CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993)

To the Employee Requesting Leave under the Family and Medical Leave Act (FMLA): Complete items 1 and 2 (and item 8, if you require leave to care for a family member). Your Health Care Provider must complete the remainder of this form. The completed form should be mailed or faxed as noted in the upper right corner.

To the Physician providing information for medical verification: 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 employees or their family members. In order 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.

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| 1. Employee's Name | 2. Patient's Name (if different from employee) |
|--------------------|--|

3. Page 3 describes what is meant by a “**serious health condition**” under the FMLA. Does the patient’s condition¹ qualify under any of the categories described? If so, please check the applicable category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ , or None of the above _____

4.a. State the approximate **date** the condition commenced, and the probable duration of the condition:

Date condition commenced: _____

Probable duration of condition or need for treatment: _____

b. Will it be necessary for the employee to work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?

_____ (answer Yes or No)

If yes, give the probable duration (of need for intermittent/part-time work):

5.a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments:

b. If the patient will be absent from work or daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of an interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

¹The Health care provider is not to disclose the underlying diagnosis without the written consent of the patient.

6.a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition**, is the employee **unable to perform work** of any kind?

(answer Yes or No)

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

7.a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require** assistance for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date

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 incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity² of more than three **consecutive calendar days** (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

(1) Treatment³ 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 treatment⁴ under the supervision of the health care provider.

3. Pregnancy

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

4. Chronic Conditions Requiring Treatments 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 incapacity² (*e.g.*, asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of Incapacity² 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.

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 Incapacity² **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).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

~**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.**

~**A regimen of continuing 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 of treatment does not include the taking of 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.**