LOS RIOS COMMUNITY COLLEGE DISTRICT
FAMILY MEDICAL LEAVE
CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(must be completed by physician)
Return to Employee Benefits Department
916·568·3070

1. Employee's Work Location & Department:	2. Employee's Supervisor & Telephone Number:
3. Name of Employee and Employee ID Number:	4. Patient's Name (if other than employee, include relationship)

5. The reverse side of this page describes what is meant by a **"serious health condition"** under the Family and Medical Leave act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

☐ (1)Hospital Care ☐ (2)Absence Plus Treatment ☐ (3)Pregnancy ☐ (4)Chronic Condition Requiring Treatment

☐ (5)Permanent/Long-term Condition Requiring Treatment ☐ (6)Multiple Treatments (Non-Chronic Conditions)

6. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of the category marked above:

7. Date Condition Commenced:	8. Probable Duration of condition:

9. Regimen of treatment to be prescribed: (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. **Include schedule of visits or treatment (even if only an estimate) if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)**

10. Is employee able to perform work of any kind? ☐ No ☐ Yes if "yes" list the functions the employee is unable to perform:

FOR CERTIFICATION RELATING TO THE CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEMS 11 THROUGH 13 BELOW AS THEY APPLY TO THE FAMILY MEMBER.

11a. Does the patient require assistance for basic medical or personal needs or safety, or for transportation? 11b. If 11a is no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patients recovery?	12. If the patient will need care only **intermittently**, please indicate the probable duration of this need:

13. **To be completed by the employee needing family leave**—When Family Leave is needed to care for a seriously-ill family member, state the care you will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or by reducing your work schedule.

Signature of Employee: **Work#** **Home#** **Date:**

14. Type of Practice (Field of specialization, if any):

Print name of physician or practitioner:

Office Telephone#: Address:

Signature of Physician:

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

2. Absence Plus Treatment

   (a) 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:

   (1) **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

   (2) **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.

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 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 or family member must be **under the continuing supervision of, but need not ne 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 there from) 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), and kidney disease (dialysis).