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**Physician’s Certification**

**FMLA**

**Employee Illness/Injury**

**Employee to complete upper portion**

|  |  |
| --- | --- |
| Employee’s Name: | Employed at: |
| I authorize any physician, medical practitioner, health care practitioners, hospital, clinic, other medical or medically related facility having information as to diagnosis, treatment or prognosis with respect to any physical and mental condition, and/or treatment of me related to this absence/illness **only**, to provide Southeastern California Conference any such information.  Employee’s Signature Date: | Date requested leave to begin |
| Date requested leave to end |

**Health Care Provider to complete appropriate portions of remainder**

|  |  |
| --- | --- |
| Employee | 1. Does this employee have a serious health condition **(See reverse side for definition.)** 2. **NO**, if you check this box go directly to the bottom of form and sign and date. 3. **YES**, (must check at least one applicable box[es] below):   Hospital Care Absence Plus Treatment  Chronic Conditions Requiring Treatments Permanent/Long-term Condition Requiring Supervision  Multiple Treatments (non-chronic condition) Pregnancy…..Estimated Date of Delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Type of leave requested:   Continuous *(answer question 4)* Intermittent/Reduced Schedule *(answer questions 3a,3b,3c&3d)*   1. a. If **intermittent leave** or a **reduced work schedule** is being considered, is it medically necessary?   Yes No   1. If **YES,** periods of incapacitation are likely to occur \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   *(how many hours or days) (week, month, year)*   1. If **YES,** please indicate the estimated number of doctor’s visits, and/or estimated duration of medical treatment, either by a health care practitioner or another provider of health services, upon referral from the health care provider: 2. If leave is **continuous,** can return to full duties with no restrictions on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Name of Health Care Provider | Specialty |
| Address | Telephone |
| Signature | Date |

***This form must be returned to: SECC Human Resource, PO Box 79990, Riverside, CA 92513-1990***

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.

1. Absence Plus Treatment
2. 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:
3. **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
4. **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.
5. Pregnancy

Any period of incapacity due to **pregnancy** or for **prenatal care qualifies for FMLA and PDL.**

1. Chronic Conditions Requiring Treatment

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

1. May cause **episodic** rather than a continuing period of incapacity2 (e.g., asthma, diabetes, epilepsy, etc.).
2. 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 sever stroke, or the terminal stages of a disease.

1. Multiple Treatment (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).

2 “Incapacity,” for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular activities due to the serious health condition, treatment therefor, or recovery therefrom.

3 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.

4 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 regiment of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bedrest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.