



OXNARD SCHOOL DISTRICT

1051 South "A" Street • Oxnard, California 93030 • 805/385-1501 • www.oxnardsd.org

MEDICAL CERTIFICATION – EMPLOYEE’S FAMILY MEMBER’S SERIOUS HEALTH CONDITION

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

1. Employee’s Name: _____

2. Patient’s Name: _____

Patient’s relationship to employee: _____

If the patient is the employee’s child, is the patient either under eighteen (18) or an adult dependent child: Yes No

3. Does the employee’s child, parent, spouse, or domestic partner have an illness, injury, impairment, or physical or mental condition which constitutes a “serious health condition?” Below is a description of what constitutes a “serious health condition” under both the FMLA and the CFRA. Does the patient’s condition qualify as a serious health condition:

Yes No

If employee will be caring for an adult child, a health care provider must certify the following:

Patient is Employee’s Adult Child

Patient is Incapable of Self Care**

Signature of Health Care Provider

Signature of Health Care Provider

4. Date medical condition or need for treatment commenced: _____

5. Probable duration of medical condition or need for treatment: _____

6. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?

7. After review of the employee’s signed statement (See Item 10 below), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.) Yes No

8. Estimate the period of time care needed or during which the employee's presence would be beneficial:

9. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule.

Yes No

Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis or to work a reduced number of hours of work in order to deal with the serious health condition of the employee or family member?

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Yes No

Reduced Schedule Leave: Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee or family member?

If yes, please indicate the part-time or reduced work schedule the employee needs:

_____ hour(s) per day; _____ days per week, from _____ through _____

Yes No

Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

If yes, please indicate the estimated frequency of the employee's need for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per appointment/treatment

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE

***** TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER

10. When family care leave is needed to care for a seriously ill family member, the employee shall state the care he or she 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 on a reduced leave schedule:

11. Printed name of health care provider: _____ Signature of Health Care Provider: _____

Date: _____

12. Employee Signature: _____

Date: _____

“Serious Health Condition” means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

1. ***Hospital Care***

Inpatient care 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. A person is considered an “inpatient” when a health care facility formally admits him or her to the facility with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such a person can be discharged or transferred to another facility and does not actually remain overnight.

**A child is “incapable of self care” if he/she requires active assistance or supervision to provide daily self care in three or more of the activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing and eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.

2. ***Absence Plus Treatment***

- (a) A period of incapacity of more than three consecutive, full calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
 - (1) Treatmentⁱ two or more times within thirty (30) days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse, 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 treatmentⁱⁱ under the supervision of the health care provider. The in-person treatment visit must take place within 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 Treatments***

A chronic condition which:

- (a) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse;
- (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (c) 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 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 incapacity of more than three full consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

ⁱ 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.

ⁱⁱ 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.