CITY OF OAKLAND

MEDICAL VERIFICATION FORM

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

(Required by the Family Medical Leave Act (FMLA) and/or California Family Rights Act (CFRA))

FOR COMPLETION BY THE EMPLOYEE:

INSTRUCTIONS to the EMPLOYEE: Please complete Employee section before giving this form to your medical provider. The FMLA/CFRA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA/CFRA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA/CFRA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee's Name: _____

Employee's Classification: _____

Patient's Name (if other than employee): _____ Relationship to Employee: _____

If patient is employee's child, is patient either under 18 or an adult dependent child: Yes ☐ No ☐

FOR COMPLETION BY THE HEALTHCARE PROVIDER:

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA/CFRA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage. Limit your responses to the condition for which the employee is seeking leave.

Do not provide the underlying diagnosis without the consent of the patient or information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Please be sure to SIGN the form on the last page.

I. Certification that a serious health condition exists: Yes ☐ No ☐
[Please see below for a description of what constitutes a "serious health condition]

II. Date condition or need for treatment commenced: _____

III. Probable duration of condition or need for treatment: _____

IV. If the certification is for the serious health condition of the **employee**, please answer the following:

- Is the medical condition pregnancy? Yes ☐ No ☐ If yes, expected delivery date: _____
- Is the employee able to perform work of any kind? If no, skip next question. Yes ☐ No ☐
- Is employee unable to perform any one of the essential functions of the employee's position? Answer after reviewing statement from employer of essential functions of employee's position or if not provided, answer these questions based upon the employee's own description of his/her job functions. Yes ☐ No ☐

V. If the certification is **for care of the employee's family member**, please answer the following:

- Does, or will, the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? Yes ☐ No ☐

- After review of the employee's signed statement (see below), is the employee's presence necessary or would it be beneficial for the care of the patient? Yes☐ No ☐

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

  _____

VI. Please answer the following questions only if the employee is asking for **intermittent leave** due to the serious health condition:

- Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee or family member? Yes ☐ No☐

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

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

    Duration:_____ hour(s) or_____ day(s)/ per episode

- 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? Yes ☐ No ☐

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

    Frequency: ___ hour(s) per day; ___ day(s) per week, from _____ through _____

- 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 healthcare practitioner or another provider of health services? Yes ☐ No ☐

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

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

    Duration:_____ hour(s) or_____ day(s)/ per appointment/treatment

Physician or Practitioner Name (please print): _____License#:_____

Address: _____ **Phone #:** _____ **Fax #:** _____

Signature of Physician or Practitioner: _____ **Date**: _____

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 an individual or family member of the individual, except as specifically allowed by this law. 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.

FOR COMPLETION BY THE EMPLOYEE

When Family Medical Leave is needed **for care of an eligible, seriously ill family member**, the employee shall state the care the employee 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 work schedule:

_____

_____

_____

Employee Signature: _____ Date: _____

SERIOUS HEALTH CONDITION

A “serious health condition” is defined as 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 or continuing treatment including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

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 heath care facility formally admits the person to the facility with the expectation that the person will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

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.

PREGNANCY

[NOTE: An employee’s own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA]
Any period of incapacity due to pregnancy or for prenatal care.

CHRONIC CONDITIONS REQUIRING TREATMENT

A chronic condition, which:
1. Requires periodic visits for treatment by a health care provider, or by a nurse of 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.).

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.

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 consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).