

Los Angeles Unified School District
FMLA CERTIFICATION OF HEALTH CARE PROVIDER

EMPLOYEE: COMPLETE THE FOLLOWING (top of this page only)

1. Employee's Name (Print) _____ Employee # _____
2. Health Insurance Provider and Member # _____
3. Work Location _____ Job Title _____
4. Is Health Condition Claimed as "Serious" under FMLA? yes no ; Is it for? self ; family .
5. Starting date of absence _____; Last date of absence (expected) _____.
6. If leave is for family member, a) state the care you will provide; b) an estimate of the period during which care will be provided; and c) a time schedule if leave is intermittent or reduced work time:

(use separate sheet if needed)
7. Sign authorization that you have fully and completely read and agree to this entire paragraph:
"I hereby authorize my health care provider to provide information related to my health condition(s) relative to the request for leave (whether under CFRA/FMLA or not) by completing this form on my behalf and returning it to LAUSD. By signing this authorization, I give my health care provider permission to respond to the District's requests for clarifications, and permission for the District to verify authenticity of the Certification below. For the employee's health condition only, if LAUSD has reason to question the validity of the certification provided, the District may require me, at District expense, to obtain the opinion of a second health care provider, designated and approved by the District. If under FMLA, the 2nd provider will not be employed by the District. I declare under penalty of perjury that all information is true and correct, and that I have not made any entries/markings in the sections for the Health Provider. "

Employee's Signature Date Signature-Family Member (or Guardian), if applicable Age, if Son/Daughter
Submit this ORIGINAL DOCUMENT in accordance with the Instructions at the bottom of page 2. FAX COPIES CANNOT BE ACCEPTED.

HEALTH CARE PROVIDER: COMPLETE THE FOLLOWING, including PAGE 2

Individual with Health Condition

1. Name of LAUSD Employee: (Provide the name as you know it): _____
2. Patient Name (if different from employee): _____ Relationship to Employee _____

This section applies to Incapacity for **Either Employee [] or Family Member []** (re Qualifying Condition)

3. Can you confirm the health condition is currently causing "a period of incapacity"? yes [] no []
4. Have you provided "continuing treatment"? yes [] no []. Date of first visit _____
5. Does the health condition qualify as "Serious", as defined by FMLA according to one or more of the criteria below? yes [] no []
6. If yes to #5, check applicable categories from A – F; see page 3 of Definition of Serious Health Condition for details. The Health Care Provider is not being requested to disclose the underlying condition without the consent of the patient.
 - [] A) In-patient, overnight Hospitalized Care
 - [] B) Serious Incapacity causing Absence of more than 3 consecutive days + Two Treatments
 - [] C) Incapacity causing Absence due to Pregnancy, or Pre-natal with Health Care Provider
 - [] D) Serious Chronic Condition causing Incapacity and requiring Treatments
 - [] E) Serious Permanent Condition, or Serious Long-term Condition
 - [] F) Multiple Treatments for Serious Health Condition (not necessarily having current incapacity)

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HEALTH CARE PROVIDER to COMPLETE: continued from page 1

*This section applies to Incapacity of **Either Employee** [] or **Family Member** [] (re Dates & Treatment)*

- 7. Anticipated date employee can return to work _____
- 8. a) Approximate date health condition began _____ b) Date incapacity began _____
c) Expected duration of condition _____ d) Expected duration of incapacity _____
- 9. Describe general nature of incapacity _____ (not requested to reveal diagnosis)
- 10. a) Does the health condition allow the employee to work intermittently? yes [] no []
b) State probable frequency/duration of intermittent absences _____
c) Does health condition allow for a reduced work schedule? yes [] no []; schedule _____
- 11. a) If more treatments are required, estimate probable # of treatments _____
b) If schedule is intermittent due to treatments, estimate interval between treatments _____
c) Estimated dates/duration of treatments _____
d) Estimate period or date of recovery from treatments _____

*This section applies ONLY to Incapacity of **Employee** (re Inability to Perform Work)*

- 12. a) List any probable restrictions upon return to job _____
_____ (use separate sheet if necessary)
b) Could the employee perform the job if any working conditions were altered? yes [] no []
Provide explanation _____ (use separate sheet)

*This section applies ONLY to Incapacity of **Family Member** (re Leaves to Care for Family Member)*

- 13. a) If leave is for family, does patient require and warrant employee's assistance? yes [] no []
b) Identify assistance necessary from employee, such as basic medical, personal needs, safety, transportation: _____
c) If patient needs care, estimate probable duration of need _____

Verification from Health Care Provider

Provide the following information pertaining to your profession:

- a) Your Name _____
- b) Your Name as Health Care Provider _____ Degree _____
- c) Specialty/Type of Practice _____ License # _____
- d) Type of License _____ Telephone # (____) _____
- e) Address _____ Zip _____

Certify to the following: "I certify that I am the treating health care provider for the above-named patient who is under my professional care. All of this information is true and correct to the best of my knowledge."

Original Signature (no stamp): _____ Date: _____

INSTRUCTIONS: Return this form to employee's site administrator. If absence is for 20 CONSECUTIVE WORKING DAYS or LESS, the form will remain at employee's site, filed in a confidential manner. If absence is for MORE than 20 consecutive working days for certificated personnel, this form will be forwarded by the site to Certificated Placement & Assignments (or to Administrative Assignments Unit, Adult Education HR or Early Childhood Education HR, as appropriate), with a copy retained at the site. (For classified personnel, retain this form at the site & follow instructions on forms for the Personnel Commission.) **DO NOT FAX. FAXED COPIES CANNOT BE ACCEPTED.**

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“SERIOUS HEALTH CONDITION” under FMLA/CFRA:

A “Serious Health Condition” means an illness, injury, impairment, or physical or medical condition which involves one of the following six definitions below. However, unless complications arise with more severe conditions, these definitions would not include cosmetic treatments (such as most treatments for acne or plastic surgery), the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease. Mental illness resulting from stress, or allergies, may be serious health conditions, but only if all the conditions within one of these six definitions are met.

[Note: Treatment includes examinations to determine if a serious health condition exists and includes evaluations of the condition. Treatment does not include physical examinations, eye examinations, or dental examinations.]

1. HOSPITAL CARE

Inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical care facility, including a period of incapacity (i.e., an inability to work or perform other regular daily activities) or subsequent treatment in connection with such inpatient care.

2. ABSENCE PLUS TREATMENT (GENERAL ABSENCE)

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.

[Note: A regimen of continuing treatment includes, for example, a course of prescription medications (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.]

3. PREGNANCY

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

[Note: An employee’s own pregnancy-related disabilities are covered by the FMLA and California Pregnancy Disability Leave Act, but are excluded from the California Family Rights Act. However, an employee caring for a qualifying family member’s disability due to pregnancy would potentially be covered by FMLA and CFRA, but not the California Pregnancy Disability Leave Act.]

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 that 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 a health care provider, but need not be receiving active treatment. Examples include Alzheimer’s, a severe stroke, or the final stages of a terminal disease.

6. MULTIPLE TREATMENTS (not necessarily requiring incapacity at present time)

Any period of absence based on multiple treatments, including any period of recovery, by a health care provider or by a provider of healthcare 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).