LOS ANGELES UNIFIED SCHOOL DISTRICT
Personnel Commission Classified Employment Services Branch
Human Resources Certificated Assignments & Support Services

EE Name:
EMP #:

Health Care Provider Certification Form
Employee or Family Member Medical and/or Serious Health Condition
Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL)

SECTION I: For Completion by the SUPERVISOR

INSTRUCTIONS: Complete Section I and attach class description before giving this form to the employee. You may not ask an employee to disclose information other than what is permitted under the applicable regulations. Employers must maintain confidential leave records that document an employee's medical certifications/recertification, separately from the employee's personnel files.

School Site/Division	
Supervisor/Administrator	Date
Employee Name	Employee #
Employee Job Title	Regular Work Schedule

Supervisor should attach class description.

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS: You are required to submit a timely, complete and sufficient medical certification to support requests for protected absences and/or formal Leave of Absence. Submittal of the medical certification is required by LAUSD in order to obtain and/or retain leave protections. **This form should be completed and returned within 15 calendar days of request.** Failure to provide a complete and sufficient medical certification may result in the delay or denial of your request for protected absences and/or formal Leave of Absence.

RELEASE OF MEDICAL INFORMATION:
I hereby authorize any physician/health care provider who has provided medical care regarding any condition related to the current Leave of Absence request to release any or all pertinent information and records to the Los Angeles Unified School District. **DO NOT disclose a diagnosis.** By signing this authorization, I give my health care provider permission to respond to the District's requests to verify authenticity of the Certification below.

Employee's Full Name

Employee's Signature	Date
Family Member's Name (If Applicable)	Family Member's Relationship to Employee (If Applicable)
Family Member's Signature (If Applicable)	Date

If absence is for 20 CONSECUTIVE WORKING DAYS OR LESS, this form will remain at the employee's site.

If absence is for MORE THAN 20 CONSECUTIVE WORKING DAYS, a District formal Leave of Absence is required and this form will be forwarded by the employee to the appropriate personnel office, with a copy retained at the site.

Personnel Commission Classified Employment Services Branch, PH: 213.241.6300, PO Box 513307, Los Angeles, CA 90051-1307
Human Resources Certificated Assignments & Support Services, PH: 213.241.5100, PO Box 3307 (Dept. S), Los Angeles, CA 90051
Human Resources Administrative Assignments Unit, PH: 213.241.6365, PO Box 3307, Los Angeles, CA 90051
DACE Personnel Unit, 333 S. Beaudry Ave, PH: 213.241.3150, 15th Floor, Los Angeles, CA 90017
Early Childhood Education Unit, 333 S. Beaudry Ave, PH: 213.241.2404, 15th Floor, Los Angeles, CA 90017

ORIGINALS ARE REQUIRED. COPIES CANNOT BE ACCEPTED.

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SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS: Please provide complete answers to all applicable questions below and be sure to sign and date page 3. Several questions seek a response regarding the frequency or duration of a condition and/or treatment. Your answer should be your BEST ESTIMATE based upon your examination of the patient and your prognosis. Please be as specific as possible, noting that terms such as "as needed," "unknown," or "indeterminate" may not be sufficient to determine FMLA, CFRA and/or PDL coverage. Limit your responses to address only the condition for which the employee is seeking protected absences and/or formal Leave of Absence.

The Genetic Information Nondiscrimination Act of 2008, Title II (GINA) prohibits employers and other entitles covered by GINA, from requesting genetic information of an individual or family member, except as specifically allowed by this law. To comply with GINA, do not provide any genetic information when responding to this request for medical information.

PART A: MEDICAL FACTS OF PATIENT'S CONDITION(S)

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

2. Does the employee's medical condition qualify as a serious health condition? YES NO

3. If yes, check any/all definitions of serious health conditions below (A-F) that apply. (Detailed List Attached)

   A. In-patient care in a hospital, hospice, or residential medical care facility
   - If yes, provide date(s) of admission: _____

   B. Serious incapacity of more than 3 consecutive calendar days plus 2 treatments. If yes, will the patient:
   - Need to have treatment visits at least twice per year due to the condition? YES NO
   - Have medication, other than over-the-counter, prescribed? YES NO
   - Be evaluated or treated by other health care provider(s)? YES NO

   C. Incapacity causing absence due to pregnancy or pre-natal care
   - Expected delivery date: _____

   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

4. Answer question "A" based upon either the attached job description of the employee's essential functions or the employee's own description of his/her job functions, if the job description is not provided.

   A. If this certification is to cover protected absence(s) (FMLA/CFRA/PDL) for the serious health condition of the employee, please answer the following:

   Does the condition create periods of incapacity that prevent the employee from performing one or more of his/her job functions? YES NO

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

   Does (or will) the patient require assistance from the employee for basic medical hygiene, nutritional needs, safety, transportation, psychological comfort, and/or arranging for third-party care? YES NO

Answer questions 5 & 6 for a District formal Leave of Absence only.

5. Is the employee's medical condition work related (Industrial Injury)? YES NO
6. Is the employee's medical condition a Permanent Disability (Leave of Absence only)? YES NO

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SECTION III: For Completion by the HEALTH CARE PROVIDER, CONTINUED

PART B: AMOUNT OF LEAVE NEEDED

1. **Single Continuous Period of Time**: Is it medically necessary for the employee to be absent from work due to the medical condition or serious health condition of the employee or family member? Yes No

   If yes, estimate the beginning and ending dates for the period of incapacity FROM: _____ THROUGH _____

Answer questions 2, 3, and/or 4 only if the employee requires leave on a reduced or intermittent basis.

2. **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, indicate the part-time or reduced work schedule. The employee should work no more than:

   _____ Hours per day; _____ days per week; FROM _____ THROUGH _____

   Notes: _____

3. **Medical Appointments or Treatment**: Is it medically necessary for the employee to be absent from work for medical appointments and/or treatment due to the serious health condition of the employee or family member? Yes No

   If yes, estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each, including any travel time and recovery period:

   Frequency: _____times per _____week(s) **OR** _____month(s)

   Duration: _____hour(s) **OR** _____day(s) per appointment/treatment

   APPOINTMENTS/TREATMENT CERTIFICATION DURATION: FROM _____ THROUGH _____

   Notes: _____

4. **Intermittent Leave:** Is it medically necessary for the employee to be absent from work on an intermittent basis due to the serious health condition of the employee or family member? Yes No

   If yes, based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may experience (e.g., 1 episode every 3 months lasting 1 -2 days):

   Frequency: _____times per _____week(s) **OR** _____month(s)

   Duration: _____hour(s) **OR** _____day(s) per episode

   INTERMITTENT FLARE-UPS CERTIFICATION DURATION: FROM _____ THROUGH _____

   Notes: _____

Health Care Provider Verification Please provide the following information pertaining to your practice:

Provider's Name as Health Care Provider	
Type of Practice/Medical Specialty	License Number
Address	Zip Code
Phone	Fax

Endorse the following statement: "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:_____ Date:_____

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Serious Health Condition

A. 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 person can be discharged or transferred to another facility and does not actually remain overnight.

B. Absence plus Treatment
   a. A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
      i. 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
      ii. 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.

C. Pregnancy; any period of incapacity due to pregnancy or for prenatal care

D. Chronic Conditions Requiring Treatment
   A chronic condition which:
   a. 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;
   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.)

E. 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.

F. Multiple Treatments (Non-Chronic Conditions)
   A 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 (3) 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).