

CITY OF RIVERSIDE
FAMILY, MEDICAL, PREGNANCY DISABILITY AND/OR MILITARY CAREGIVER LEAVE
MEDICAL CERTIFICATION

Employee Information

(To be completed by employee; fill out all information that applies.)

Employee _____ Date _____
ID # _____ Department/Division _____
Phone Number (Home) _____ Phone Number (Work) _____
Current Address _____
Position _____
Name of family member with serious health condition (if different than employee) _____
For military caregiver leave, name of spouse, child, parent, or next of kin for whom you are requesting
leave to care _____
Date Condition Began _____ Date Condition Expected to End _____
Date Leave Commenced _____ Date of Planned Return _____

Medical Release

(To be completed by employee)

I authorize the release of any medical information necessary to process my request for Family, Medical, Pregnancy Disability and/or Military Caregiver Leave.

Employee Signature _____ Date _____

Medical Certification for Leave

(To be completed by health care provider)

The federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) defines a serious health condition. Does the patient's condition qualify under any of the categories listed on pages 2 and 3 of this form? If so, check the appropriate category:

- (1) (2) (3) (4) (5) (6)

Explanation of extent to which employee is unable to perform the essential functions of his or her job, or is needed to care for an ill spouse; child; parent; registered domestic partner; or a covered servicemember injured in the line of duty on active duty who is a spouse, child, parent, or next of kin. _____

Military Caregiver Medical Certification for Leave

(To be completed by a United States Department of Defense (DOD) health care provider or a health care provider who is either: (1) A U.S. Department Of Veterans Affairs Health Care Provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider)

The covered servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

- (VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately
- (SI) Seriously Ill/Injured** – Illness/Injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside.
- Other Ill/Injured** – A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

Intermittent Leave or Leave on a Reduced Leave Schedule

Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the normal work schedule in order to deal with the serious health condition of the employee, family member, registered domestic partner, or family member and/or next of kin who is a covered servicemember injured in the line of duty on active duty?

Yes No If yes, comment below and include recommended work schedule _____

Health Care Provider Signature _____ Date _____
Health Care Provider Name _____ Office Phone _____
(Please Print)

Health Care Provider Comments

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 incapacity or subsequent treatment in connection with or consequent to such inpatient care.

(2) 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.

(3) 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.

(4) 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.).

(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 Treatment (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery there from) 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), kidney disease (dialysis).

Medical Certification to Return to Work

(To be completed by health care provider)

I have examined the employee whose name appears at the top of this page and certify that s/he is able to return to work and perform all essential job functions.

Health Care Provider Signature _____

Date _____

Health Care Provider Name _____

Phone Number _____