Yosemite Community College District
Human Resources Operations
Benefits Office

HEALTH CARE PROVIDER CERTIFICATION STATEMENT

1. Name of Employee: _____

2. Patient's Name (if other than employee): _____

   Date health condition or need for treatment began **(Note: The health care provider is not to disclose the underlying diagnosis without the consent of the patient)**:

   _____

3. Expected duration of condition or need for treatment: _____

4. The attached sheet describes what is meant by a "serious health condition**" (SHC)** under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient's condition qualify under any of the categories described? If so, please check the appropriate category:

   (1)☐ (2)☐ (3)☐ (4)☐ (5)☐ (6)☐

5. If the certification is for the **SHC** of the employee, please answer the following:

YES	NO	
☐	☐	Is the employee able to perform work of any kind? (If no, skip next question)
☐	☐	Is the employee unable to perform one or more of the essential functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

6. If the certification is for the care of the employee's qualifying person, please answer the following:

YES	NO	
☐	☐	Does (or will) the patient require assistance for basic medical, hygiene, nutritional, safety or transportation needs?
☐	☐	After review of the employee's signed statement (See **Item 9 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 qualifying person.)

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

8. Answer the following question only if the employee is asking for intermittent leave or a reduced work schedule:

YES	NO	
☐	☐	Is it necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or qualifying person?

If the answer to #8 is yes, please indicate the estimated number of visits, and/or estimated duration of the medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider.

ITEM 9 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

9. When family care leave is needed to care for a seriously ill family member, the employee shall state the care that 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 work schedule:

Please submit a doctor's note for period of medical leave on physician's letterhead

10. Health Care Provider Signature: _____

11. Print Name: _____

Date: _____Office Phone Number: _____

Medical Health Information Release:

12. I authorize the release of any health information necessary to process the above request.

Patient's Signature: _____ Date:_____

13. Print Name: _____

14. Please return this form to Yosemite Community College District, Office of Human Resources P.O. Box 4065, Modesto, CA 95352.