LOS ANGELES UNIFIED SCHOOL DISTRICT

ATTACHMENT A
EE Name:
EMP #:

Health Care Provider Certification Form

Employee or Family Member's 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 the 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 informal and/or formal protected leaves 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 your request.** Failure to provide a complete and sufficient medical certification may result in the delay or denial of your request for a protected 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 this Health Care Certification Form 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 below, I give my health care provider permission to respond to the District's requests to verify the authenticity of the information listed herein this Health Care Provider Certification.

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

The Health Care Provider Certification shall be kept in a ***confidential*** file separate from the employee's regular personnel records at the employee's worksite.

Certificated Employees Only

If leave is for MORE THAN 20 CONSECUTIVE WORKING DAYS, a formal Leave of Absence (HR Form 1065) is required. Please forward both - HR Form 1065 and your Health Care Provider Certification to the appropriate personnel office:

- ☐ Early Childhood Education Unit, 333 S. Beaudry Ave, PH: 213.241.2404, 15th Floor, Los Angeles, CA 90017
- ☐ Division of Adult and Career Education Personnel Unit, 333 S. Beaudry Ave, PH: 213.241.3150, 15th Floor, Los Angeles, CA 90017
- ☐ Human Resources Administrative Assignments Unit, PH: 213.241.6365, PO Box 3307, Los Angeles, CA 90051
- ☐ Human Resources Certificated Assignments & Support Services, PH: 213.241.5100, PO Box 3307 (Dept. S), Los Angeles, CA 90051

PLEASESUBMIT ORIGINAL HEALTH CARE PROVIDER CERTIFICATION FORMS

LOS ANGELES UNIFIED SCHOOL DISTRICT

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 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 on 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 a protected leave of absence.

The Genetic Information Nondiscrimination Act of 2008, Title II (GINA) prohibits employers and other entities 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, the patient's first health care provider visit (in-person or tele med) is/was within the first 7 days of incapacity with:
   - 2 or more treatments within 30 days of the first day of incapacity; and/or YES ☐ NO ☐
   - 1 treatment which results in a continuing regimen of care that includes:
     - Medication, other than over the counter, prescribed; and/or YES ☐ NO ☐
     - Referral to and/or evaluated or treated by other health care provider(s)? YES ☐ NO ☐

   ☐ C. Incapacity causing leave due to pregnancy or prenatal 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 a 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 ☐

LOS ANGELES UNIFIED SCHOOL DISTRICT
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 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 Work 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:_____

LOS ANGELES UNIFIED SCHOOL DISTRICT

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)

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 full calendar days (including any subsequent treatment or period of incapacity relating to the same condition) with the first visit taking place within the first 7 days of incapacity, 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 the 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).