

Handout #1 - FMLA REQUEST FORMS

FMLA, CFRA, SDI

Example form from CalHR

“Notice of Eligibility and Rights and Responsibilities”

Example from DFEH (employers are encouraged to use)

“Certification of Health Care Provider”

Print Form

Reset Form

**FAMILY AND MEDICAL LEAVE ACT (FMLA)
 AND CALIFORNIA FAMILY RIGHTS ACT (CFRA)**

Part A. Notice of Eligibility

Eligibility does not mean approval. Once we obtain the information from you as specified in Part B, we will inform you within 5 business days, absent extenuating circumstance, whether your leave will be designated FMLA/CFRA leave and count toward your FMLA/CFRA leave entitlement.

| | | | |
|--------------------|---------------------|--------------------------|------|
| Employee Last Name | Employee First Name | Employee Middle Name | Date |
| Division/Unit | | Daytime Telephone Number | |

1. We have received your request for leave beginning on _____ through _____ for:

- ☐ The placement of a child for adoption or foster care.
- ☐ The birth of a child and/or to care for such child.
- ☐ Your pregnancy-related disability.
 (includes severe morning sickness, prenatal care, and childbirth-related disability)
- ☐ Your own serious health condition.
- ☐ The care of one of the following due to his or her own serious health condition:
 - ☐ child/child of domestic partner ☐ parent
 - ☐ spouse ☐ domestic partner
- ☐ Assisting one of the following who is deployed by the military to a foreign country:
 - ☐ child ☐ parent
 - ☐ spouse
- ☐ The care of one of the following who is a covered service member of the United State Armed Forces who has a serious injury or illness incurred in the line of duty while on active duty, or is a veteran of the Armed Forces including the National Guard and Reserves at anytime within 5 years preceding treatment for a serious injury or illness.
 - ☐ child ☐ parent
 - ☐ spouse ☐ next of kin

2. This notice is to inform you that you are eligible for:

- ☐ FMLA ☐ CFRA

See Part B for Rights and Responsibilities

3. This notice is to inform you that because of one of the following you are NOT eligible for:

- ☐ FMLA ☐ CFRA

(Only one of the following reasons may be checked although you may not be eligible for other reasons)

- ☐ You have not met the FMLA/CFRA's 12-month length of service requirement. As of the first date of requested leave, you will have approximately _____ months towards this requirement.
- ☐ You have not met the FMLA/CFRA's 1,250 hours worked requirement.

| | | | |
|--------------------|---------------------|----------------------|------|
| Employee Last Name | Employee First Name | Employee Middle Name | Date |
| | | | |

Part B. Rights and Responsibilities for Taking FMLA/CFRA Leave

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA/CFRA leave, you must return the certification provided. You have 15 calendar days from the above date to provide certification.** If sufficient information is not provided in a timely manner, your leave may be delayed or denied.

1. You must provide the information indicated below:
- ☐ Sufficient certification to support your request for leave. A certification form that sets forth the information necessary to support your request is enclosed.
 - ☐ Sufficient documentation to establish the required relationship between you and your family member (e.g., birth certificate, adoption papers, or declaration of domestic partnership).

2. Additional information is needed:
- ☐ Yes ☐ No

FMLA/CFRA Leave

1. You have a right to take up to 12 weeks of leave in a 12-month period. A 12-month period will be based on a calendar year (January 1 - December 31).
2. You have a right under FMLA military caregiver leave to take up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member who has a serious injury or illness incurred in the line of duty while on active duty. This 12-month period will commence on the first day of your approved caregiver leave.
3. Your health benefits will be maintained during any period of FMLA/CFRA unpaid leave under the same conditions as if you continued to work.
4. You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA/CFRA-protected leave. (If your leave extends beyond the end of your FMLA/CFRA entitlement, you do not have return rights under FMLA/CFRA.)
5. If you do not return to work following your leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA/CFRA leave; (2) the continuation, recurrence, or onset of a covered service member's serious injury or illness, which would entitle you to FMLA/CFRA leave; or (3) other circumstances beyond your control; you may be required to reimburse the State for the cost of health insurance premiums paid on your behalf during your leave.
6. You have the option to use your sick, vacation, and/or other leave balances, provided you meet any applicable requirements of the Memorandum of Understanding and department leave policies. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA/CFRA leave.

For conditions applicable to sick/vacation/other leave usage, please refer to the Memorandum of Understanding and department policies.



CERTIFICATION OF HEALTH CARE PROVIDER

for California Family Rights Act (CFRA) or Family and Medical Leave Act (FMLA)

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. *To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information.* "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

1. Employee Name: _____
2. Patient's Name (if other than employee): _____
 Patient's Relationship to Employee: _____
 If patient is employee's child, is patient either under 18 or an adult dependent child: _____ Yes _____ No
3. Date medical condition or need for treatment commenced [NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF THE PATIENT]: _____
4. Probable duration of medical condition or need for treatment: _____
5. Below is a description of what constitutes a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient's condition qualify as a serious health condition? _____ Yes _____ No
6. If the certification is for the serious health condition of the employee, please answer the following:
 Is the employee able to perform work of any kind? (If "No," skip next question) _____ Yes _____ No
 Is employee unable to perform any 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.) _____ Yes _____ No
7. If the certification is for the care of the employee's family member, please answer the following:
 Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? _____ Yes _____ No
 After review of the employee's signed statement (see item 10 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 family member.) _____ Yes _____ No

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

9. Please answer the following questions only if the employee is asking for intermittent leave or a reduced work schedule:

Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee or family member?

_____ Yes _____ No

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s) *Duration:* _____ hours or _____ day(s) per episode

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, please indicate the part-time or reduced work schedule the employee needs:

Frequency: _____ hour(s) per day; _____ days per week, from _____ through _____.

Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

_____ Yes _____ No

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: _____ times per _____ week(s) _____ month(s) *Duration:* _____ hours or _____ day(s) per apt./treatment

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

****TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER.

10. When family care leave is needed to care for a seriously-ill family member, the employee shall state the care the employee 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:

Printed Name of Health Care Provider: _____

SIGNATURE OF HEALTH CARE PROVIDER

DATE

SIGNATURE OF EMPLOYEE

DATE



SERIOUS HEALTH CONDITION

“Serious health condition” means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

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 the person to the facility with the expectation that the person 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.

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.

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.

CHRONIC CONDITIONS REQUIRING TREATMENT

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.).

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.

MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS)

Any 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 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).