On employer Letterhead

☐ **VIA REGULAR MAIL** ☐ **VIA E-MAIL** ☐ **OTHER:** _____

NOTICE OF ELIGIBILITY, RIGHTS AND RESPONSIBILITIES
CALIFORNIA FAMILY RIGHTS ACT

Insert date

Mr. Employee First & Last Name
Employee Address
City, State, Zip

Dear insert employee name,

We have received information that you requested or otherwise indicated that you *may* have of need of leave that may be protected by the California Family Rights Act ("CFRA").

PART A – NOTICE OF ELIGIBILITY

We are writing to inform you that (select ONE option below):

☐ you are eligible for leave under CFRA. Before we can determine whether your absence qualifies as CFRA leave you will need to submit to us sufficient medical certification from a treating healthcare provider to support your request for leave. A certification form that outlines the information necessary for this request is enclosed. We request that you return it, or the healthcare provider's preferred template within 15 calendar days.

☐ you are not eligible for CFRAleave because you do not work for an employer with 5 employees or more.

☐ you are not eligible for CFRA leave at this time because you have not met one or more of the required eligibility criteria of 1. working for us for at least one year, *and* 2. having at least 1250 hours of *actual straight time worked* (e.g. not overtime) with us in the last year. We will, however, be able to explore your rights to reasonable accommodation if you have a disabling medical condition consistent with the California Fair Employment and Housing Act ("FEHA")and, if covered, by the Americans with Disabilities Act ("ADA").

☐ you are not eligible for CFRA leave at this time because you have not yet exhausted the Pregnancy Disability Leave (PDL) available to you. (After PDL, and childbirth recovery, you may be eligible for CFRA leave, including baby bonding).

☐ you are eligible for CFRA leave, but do not have any remaining available CFRA leave at this time because you have already taken and exhausted all 12 weeks of the CFRA leave available to you in the applicable 12 month period.

☐ you are not eligible for CFRA leave at this time because the family member for which you are requesting leave does not meet the definition of family under the CFRA.

PART B – NOTICE OF RIGHTS AND RESPONSIBILITIES *(remove part B if employee is not eligible for CFRA)*

As explained in Part A, you meet the eligibility requirements for taking CFRA leave and CFRA leave is available to you in the applicable 12-month period. However, before we can determine whether your absence qualifies as CFRA leave, ***please return the following information to us by insert the date that is 15 calendar days from the date of providing the notice to the employee:****(select all that apply)*

☐ Sufficient Medical Certification from a healthcare provider to support your request for leave *in advance* of the need impacting work. (an optional Certification form is enclosed)

☐ (For family care, and only if required consistently by employer for all cases) Sufficient documentation to establish the required relationship between you and your family member.

☐ Other information needed: (e.g. request for authorized leave, requests for use of accrued leave to supplement the unpaid CFRA leave protection, information regarding any wage replacement benefits and/or leave integration to be used during time off, etc.)

*Please note, if you are already, or may be absent from work before the deadline indicated above due to the medical condition causing the need for leave, *please be aware of your responsibility to submit medical certification in advance of the impact of work or as soon as practical in emergency situations*. Please also note, if sufficient medical information is not provided in a timely manner, leave may be denied or delayed in approval.

You will have the following *responsibilities while on leave*:

- Contact *insert name, phone number and email* to discuss whether you need to make arrangements to continue to make your share of the premium payments on enrolled benefit plans either while you are on leave or upon the end of your leave.
- Provide *insert name, available at phone number and email* who will serve as your leave liaison to provide periodic reports of your status and intent to return to work, and with updated medical certification prior to the expiration of current certification on file.

- If using designated intermittent leave, or whenever absent without a supporting medical certification on file, follow your department's regular call in procedures to report absences adding the indication of *CFRA-related absence*.

- If the circumstances of your leave change, notify us as soon as you learn of the change, with *at least two (2) workdays prior* to the date you intend to report for work (for returning early) or to the date you were intended to return (for requesting a leave extension).

You will have the following *rights while on leave*:

- You have the right to up to 12 weeks of unpaid leave per year calculated via a rolling 12-month period measured backward from the date of any qualified leave usage. (*Employers: check your policies or with legal counsel to be sure that this best practice option matches anything your policy or past practices might require. If your policies and practices are silent, use this best practice recommendation. If your existing language conflicts, consider changing the highlighted section to "the designated calendar period."*).

- Your group health benefits must be maintained during any period of unpaid leave up to 12 weeks under the same conditions as if you continued to work.

- 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 qualified leave. (If your leave extends beyond the end of your qualified leave entitlement, you do not have return rights under the law.)

- If you do not return to work following qualified leave for a reason other than : 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to qualified leave; 2) other circumstances beyond your control, you may be required to reimburse the organization for our share of the health insurance premiums paid on your behalf during your qualified leave.

- If we do not inform you of any enforceable policy or contract agreement that would require you to use discretionary accrued leaves while taking your unpaid CFRA-qualified leave, you have the right to take accrued, unused, discretionary leave balances provided you meet any applicable requirements of the leave policy, procedures, and all applicable laws. The use of paid leave accruals would run concurrently as a supplement to CFRA's leave benefit with is unpaid.

Once we obtain the information from you requested in Part B above, we will inform you whether your leave will be designated as CFRA leave and how the time away will impact your available medical leave.

If you have any questions or concerns regarding this information please contact the leave liaison identified above.

Sincerely,

Printed name
Title

cc: Confidential Medical File

Enclosures: Medical Certification Form, Copy of Employee's Job Description, CFRA Poster

On employer Letterhead

☐ **VIA REGULAR MAIL** ☐ **VIA E-MAIL** ☐ **OTHER:** _____

NOTICE OF ELIGIBILITY, RIGHTS AND RESPONSIBILITIES
PREGNANCY DISABILITY LEAVE

Insert date

Ms. Employee First & Last Name
Employee Address
City, State, Zip

Dear insert employee name,

We have received information that you requested or otherwise indicated that you *may* have of need of leave that may be protected by theCalifornia Pregnancy Disability Leave ("PDL").

PART A – NOTICE OF ELIGIBILITY

We are writing to inform you that all female employees are eligible from the date of hire for Pregnancy Disability Leave ("PDL") for any pregnancy related or childbirth recovery accommodation needs.

PART B – NOTICE OF RIGHTS AND RESPONSIBILITIES

As explained in Part A, you meet the eligibility requirements for taking PDL leave for up to 17 1/3 weeks. However, before we can determine whether your absence qualifies as PDL leave, ***please return the following information to us by insert the date that is 15 calendar days from the date of providing the notice to the employee***:**(select all that apply)*

☐ Sufficient Medical Certification from a healthcare provider to support your request for leave *in advance* of the need impacting work. (an optional Pregnancy Certification form is enclosed).

*Please note, if you are already, or may be absent from work before the deadline indicated above due to the medical condition causing the need for leave, *please be aware of your responsibility to submit medical certification in advance of the impact of work or as soon as practical in emergency situations*. Please also note, if sufficient medical information is not provided in a timely manner, leave may be denied or delayed in approval.

You will have the following *responsibilities while on leave*:

- Contact *insert name, phone number and email* to discuss whether you need to make arrangements to continue to make your share of the premium payments on enrolled benefit plans either while you are on leave or upon the end of your leave.

- Provide *insert name, available at phone number and email,* who will serve as your leave liaison, with your personal telephone & email address for use while on leave.

- Provide at least 30 days' advance notice for foreseeable events whenever possible (such as the expected birth of a child or a planned medical treatment for yourself). For events that are unforeseeable, provide verbal notice, (as a minimum requirement), as soon as you learn of the need for the leave. Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

- Provide your leave liaison with periodic reports of your status and intent to return to work, and with updated medical certification prior to the expiration of any previous certification on file.

- If using designated *intermittent* leave, or whenever absent without a supporting medical certification on file related to your condition, follow your department's regular call in procedures to report absences adding the indication of *PDL-related absence*.

- If the circumstances of your leave change, notify us as soon as you learn of the change, with *at least two (2) workdays prior* to

You will have the following *rights while on leave*:

- You have the right to reasonable accommodation during pregnancy such as a stool or chair, or allowing more frequent breaks, or even, with sufficient notice to obtain a temporary transfer to a less strenuous or hazardous position (where one is available) or duties if medically needed because of your pregnancy. (In this circumstance, sufficient notice means 30 days advance notice if the need for PDL accommodation or transfer is foreseeable, otherwise as soon as practicable if the need is emergent or unforeseeable.)

- You have the right to up to 17 1/3 weeks of unpaid leave per pregnancy

- Your group health benefits must be maintained during any period of unpaid PDL leave up to 17 1/3 weeks under the same conditions as if you continued to work.

- You must be reinstated to the same job or in some cases to an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from qualified PDL leave. (If your leave extends beyond the end of your qualified leave entitlement(s), you do not have return rights under the law.)

- If you do not return to work following qualified leave for a reason other than : 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to qualified leave; 2) other circumstances beyond your control, you may be required to reimburse the organization for our share of the health insurance premiums paid on your behalf during your qualified leave.

- During PDL leave you may be required to use accrued *sick leave, but not vacation time or other accrued personal time off (including undifferentiated paid time off (PTO)*. You may, however, *choose to use* any accrued leave banks during your unpaid PDL leave within the provisions of the accrued leaves policy to supplement your unpaid PDL leave with paid leave accruals.

- CFRA leave entitlements may not be used at the same time as PDL leave. This means that if you are now CFRA eligible, this unpaid leave entitlement may be reserved for use after PDL exhausts for an additional 12 weeks either intermittently or continuously. One of the many eligible uses for CFRA leave includes bonding with a newborn child before the baby's first birthday. Feel free to ask more about CFRA benefits to learn whether you meet eligibility criteria and have CFRA leave available for use.

Once we obtain the information from you requested in Part B above, we will inform you whether your leave will be designated as PDL leave.

If you have any questions or concerns regarding this information please contact the leave liaison identified above.

Sincerely,

Printed name
Title

cc: Confidential Medical File
Enclosures: Pregnancy Disability Certification Form, Copy of Employee's Job Description
DFEH PDL Poster (PDL DFEH-E09P)

On employer Letterhead

☐ **VIA REGULAR MAIL** ☐ **VIA E-MAIL** ☐ **OTHER:** _____

NOTICE OF DESIGNATION REGARDING MEDICAL LEAVE REQUEST
CALIFORNIA FAMILY RIGHTS ACT

Insert date

Mr. Employee First & Last Name
Employee Address
City, State, Zip

Dear insert employee name,

We have reviewed the medical leave documentation that you have provided and your request for leave related to (select only one)

☐ your own serious health condition.

☐ bonding with a newly born, adopted, or legally placed foster child.

☐ providing family care for your qualifying family member named here: …list qualifying family relation here… (choose from this available list: *parent, child, spouse, registered domestic partner, grandparent, grandchild, and sibling,*)

☐ attending to a qualifying exigency related to the covered active duty or call to covered active duty of an employee's spouse, domestic partner, child, or parent in the Armed Forces of the United States.

Based on the information provided your leave request is (select only one)

☐ your leave request is ***approved*** and will be designated as from insert start date to insert end date .

☐ your leave request is ***delayed*** pending additional medical clarification related to note specific clarification needed (e.g. measurable calendar period for leave needs) .

☐ your leave request is ***denied***. Note, all denied requests related to *your own medical conditions* will be reviewed for additional accommodation options related to the Fair Employment and Housing Act ("FEHA") and the Americans with Disabilities Act ("ADA").

ADDITIONAL INSTRUCTIONS *(remove this additional instructions section if leave is not approved above)*

If leave is designated related to your own medical condition, be sure to submit a release to return to work from your treating healthcare provider at least two (2) business days prior to your return to work date. *The law requires that you notify us as soon as practicable if the dates of your scheduled leave change or are extended or were initially unknown*. Should you need to request a leave extension, be sure to provide an updated medical note no later than 4 PM on the last business day of your authorized leave period designated in this letter. With these goals in mind, a physician's certification to either release you to return to work or to request extended additional leave is enclosed. You may also submit a medical note of your health care provider's choosing with sufficient information.

Should you fail to provide any requested medical clarification, fail to return to work at the end of your leave, or fail to provide certification of your need for additional leave, we do not guarantee reinstatement to your prior position assignment.

If you have been designated for intermittent leave, we will provide you with the leave the health care provider indicates is necessary to the extent required by law. However, we reserve the right to reassign you to a position with equivalent pay and benefits during your leave if another position is better suited to your new temporary schedule. We will notify you if a temporary reassignment will be made. Please also follow your department's regular call-in procedures to report all absences related to this protected intermittent leave noting only at the time of reporting including the reference as "part of my protected leave."

If you are eligible and choose to file an application for or receive any wage replacement benefits it is your responsibility to notify your payroll processor prior to receiving such paid leave benefits.

Your designated leave use will count against the 12-week entitlement for CFRA leave available to you for qualifying conditions.

All additional information requested in this letter, and any questions about qualified leave should be directed to your leave liaison, *insert name, available at email, and phone number.*

Sincerely,

Printed name
Title

cc: Confidential Medical File

Enclosures: Release to Return to Work Form, Copy of Employee's Job Description, Any employer sponsored short term disability or wage replacement claim form and plan information (if any, e.g. worker's compensation's temporary disability, short term disability from the EDD or another privately contracted vendor)

On employer Letterhead

☐ **VIA REGULAR MAIL** ☐ **VIA E-MAIL** ☐ **OTHER:** _____

NOTICE OF DESIGNATION REGARDING MEDICAL LEAVE REQUEST
PREGNANCY DISABILITY LEAVE

Insert date

Ms. Employee First & Last Name
Employee Address
City, State, Zip

Dear insert employee name,

We have reviewed the medical documentation that you have provided and your request for leave related to pregnancy.

Based on the information provided your leave request is (select only one)

☐ your leave request is ***approved*** and will be designated as from insert start date to insert end date on a (select one) ☐ continuous basis ☐ intermittent basis as detailed here: note the medically indicated in frequency scope and duration of medically recommended intermittent leave (e.g. up to 3 times per month up to 2 days in a row for unforeseeable flare ups)

☐ your leave request is ***delayed*** pending additional medical clarification related to note specific clarification needed (e.g., measurable calendar period for leave needs) .

☐ your leave request is ***denied***. Note, all denied requests related to *your own medical conditions* will be reviewed for additional accommodation options related to the Fair Employment and Housing Act ("FEHA") (and for employers with 15 or more employees, also related to the Americans with Disabilities Act ("ADA"). Additional medical information may be required to activate this type of protected medical leave.

ADDITIONAL INSTRUCTIONS *(remove these additional instructions section if leave is not approved above)*

If leave is designated continuously, please be sure to submit a release to return to work from your treating healthcare provider at least two (2) business days prior to your return to work

date. *The law requires that you notify us as soon as practicable if the dates of your scheduled leave change or are extended or were initially unknown*. Should you need to request a leave extension, be sure to provide an updated medical note no later than 4 PM on the last business day of your authorized leave period designated in this letter. With these goals in mind, a physician's certification to either release you to return to work or to request extended additional leave is enclosed. You may also submit a medical note of your health care provider's choosing with sufficient information.

Should you fail to provide any requested medical clarification, fail to return to work at the end of your leave, or fail to provide certification of your need for additional leave, we do not guarantee reinstatement to your prior position assignment.

If you have been designated for intermittent leave, we will provide you with the leave the health care provider indicates is necessary to the extent required by law. However, we reserve the right to reassign you to a position with equivalent pay and benefits during your leave if another position is better suited to your new temporary schedule. We will notify you if a temporary reassignment will be made. Please also follow your department's regular call-in procedures to report all absences related to this protected intermittent leave noting only at the time of reporting including the reference as "part of my protected leave."

If you are eligible and choose to file an application for or receive any wage replacement benefits it is your responsibility to notify your payroll processor prior to receiving such paid leave benefits. You will not be required to use vacation time or other accrued personal time off (including undifferentiated paid time off (PTO) during pregnancy disability leave but you may choose to use these leave accruals within policy provisions in conjunction with your time off.

Your designated leave use will count against the 17 1/3-week entitlement for PDL leave available to you for pregnancy disability and recovery from pregnancy or childbirth.

All additional information requested in this letter, and any questions about qualified leave should be directed to your leave liaison, *insert name, available at email, and phone number.*

Sincerely,

Printed name
Title

cc: Confidential Medical File

Enclosures: Release to Return to Work Form, Copy of Employee's Job Description, Any employer sponsored short term disability or wage replacement claim form and plan information (if any, e.g., worker's compensation's temporary disability, short term disability from the EDD or another privately contracted vendor)

Certification of Health Care Provider

for California Family Rights Act (CFRA)

Employee's Disclosed Information	
Employee Name:	Patient's Name *(if not employee)*:
Health Care Provider Name:	Relationship of Employee to Patient:
Employee's Job Title:	Personal Phone & Email:

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. Patient's Name:_____
   Is patient the employee's family member (i.e., child, spouse, or domestic partner, grandparent, grandchild, sibling, parent)? ____ Yes ____ No

   (Note: "child" includes a biological, adopted, foster child, a stepchild, a legal ward, a child of the employee's domestic partner, and a person to whom the employee stands in loco parentis.)

   Patient's relationship to employee:_____

2. Date medical condition or need for treatment commenced:_____
   [NOTE: PLEASE DO NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS]

3. Anticipated duration of the current need for treatment:_____
   [NOTE: PLEASE INDICATE A MEASURABLE CALENDAR PERIOD (e.g. 6 WEEKS) OR DATE RANGE (e.g. 1/1/21- 2/15/21)]

4. A description of what constitutes a "serious health condition" under the California Family Rights Act (CFRA) is included on page 3 of this document.
   Does the patient's condition qualify as a serious health condition? ____ Yes ____ No

5. If the certification is for the **serious health condition of the employee**, please answer the following:

   a. Is the employee able to perform work of any kind? ____ Yes ____ No
      (If "No," skip next question)

   b. Is employee unable to perform any one or more of the essential functions of employee's position? ____ Yes ____ No

   c. Is the employee able to work an intermittent work schedule and/or require other accommodations? ____ Yes ____ No

   d. If yes, please describe nature of work restrictions:_____

      Likely Duration:_____

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

   a. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ____ Yes ____ No

   b. Does the condition warrant the participation of the employee? ____ Yes ____ No
   (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

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

8. Please answer the following questions only if the employee is asking for intermittent leave:

   ***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 (e.g. **flare ups** of the condition)? ____ Yes ____ No

   If yes, please indicate the estimated frequency of the employee's need for intermittent **leave due to unforeseeable episodes of incapacity**, 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

   ***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

   _____
   _____
   _____

PRINTED NAME OF HEALTH CARE PROVIDER:_____

_____

SIGNATURE OF HEALTH CARE PROVIDER: DATE:

TYPE OF HEALTH CARE PROVIDER:_____ LICENSE #_____

ADDRESS:_____ CITY:_____ STATE:____ ZIP CODE:_____

Definition of Health Care Provider:

Under Department of Labor regulations for the Family and Medical Leave Act and the State of California Family Rights Act, "health care provider" is defined as: a doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices; a podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, clinical social worker, or physician assistant who is authorized to practice by the State and performing within the scope of his or her practice as defined by State law; a Christian Science practitioner listed with the First Church of Christ, Scientist, in Boston, Massachusetts; or any health care provider from whom the employer of the employee's group health plan benefits manager will accept a medical certification to substantiate a claim for benefits.

Serious Health Condition

"Serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either (A) inpatient care in a hospital, hospice, or residential health care facility; or (B) continuing treatment or continuing supervision by a health care provider.

A serious health condition generally is not:

- Allergies, stress, or substance abuse unless inpatient hospital care is required, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term condition; or
- Voluntary treatment or surgery (unless inpatient hospital care is required.)

CERTIFICATION OF PHYSICIAN FOR PREGNANCY DISABILITY

Employee Name:_____

Job Title: _____ **Employer Name**: _____

☐ **The employee is** DISABLED BECAUSE OF PREGNANCY, CHILDBIRTH OR RELATED MEDICAL CONDITIONS

Start Date: _____ **Anticipated End Date**: _____

Please indicate all medically necessary workplace accommodations below:

☐ The employee is **ABLE TO WORK AND TO PERFORM THE ESSENTIAL FUNCTIONS OF THE JOB WITHOUT UNDUE RISK** to self, others, or to the successful completion of pregnancy.

INTERMITTENT LEAVE

☐ The employee needs **ROUTINE FORESEEABLE PRENATAL CARE VISITS**

up to _____ times per ☐ week *or* ☐ month with

each visit lasting up to _____ hours at a time.

☐ The employee needs **BOTH**

- the **FORESEEABLE APPOINTMENT REGIMEN OUTLINED ABOVE**

and

- may also have **OCCASIONS OF UNFORESEEABLE EPISODIC FLARE-UPS** related to the pregnancy as indicated below:

Up to _____ days/hours (circle one) at a time,
up to _____ days in a row,
not to exceed _____ total days per month.

CONTINUOUS LEAVE

☐ The employee is **UNABLE TO WORK AT ALL FROM**

START Date: _____ to **ANTICIPATED END Date**: _____

HEALTHCARE PROVIDER'S SIGNATURE & INFO.

Physician/Practitioner Signature: _____ Date: _____

Type of Health Care Provider: _____ Phone: _____

Address: _____

City: _____ Zip: _____

BABY BONDING / CHILD PLACEMENT LEAVE REQUEST

To be completed by the employee

Employee Name: _____ **Employer Name:** _____

Child's Name: _____ **Relationship to Employee:** _____

I would like to request Child Bonding Leave of Absence for the period below:

BEGINNING ON: _____ **ENDING ON:** _____

RETURNING TO WORK ON: _____

I acknowledge that my employer may require me to use accrued vacation or other discretionary leaves prior to converting to unpaid leave during this leave of absence. I also understand that it is my responsibility to work with my employer in advance if I intend to request the integration of any other wage-replacement benefit for which I may be eligible during this period of leave.

Employee Signature: _____ **Date:** _____

It is the employee's responsibility to ensure the top request form is completed and returned to their designated leave liaison in advance of any leave use to request approval of leave. A 2nd copy of the form may be submitted to complete the certification of birth or placement of the child with the employee after birth or placement if leave was not foreseeable.

Medical or Legal Certification of Parental Authority

To be completed by a medical or legal authority

Birth

For the birth of a child of the employee.

Birth date of the Child: _____

Placement / Adoption

For the adoption or foster care placement of a child with the employee.

Date the employee obtained physical & legal custody of the child: _____

Health Care Provider Information

_____ _____
Health Care Provider Signature **Date**

_____
Type of Health Care Provider:

_____
Address

_____ _____ _____
City **State** **Zip**

_(_____)_____-_____
Phone

Court Authority Information

_____ _____
Court Authority Signature **Date**

_____
Type Court Authority:

_____
Address

_____ _____ _____
City **State** **Zip**

_(_____)_____-_____
Phone

Return to your designated leave liaison *in advance of* leave use

Release to Return to Full Duties Certification

Employee Information	
Employee Name:	Patient's Name: *(if other than employee)*
Health Care Provider Name:	Relationship of Employee to Patient:

Questions regarding employee's job duties may be addressed to employee's supervisor.

Employee's supervisor:_____ Phone:_____

Employer name:_____

Health Care Provider Section

1. **Is the employee released to return to work?** (please answer each item below):

   ☐ Yes, the employee may complete all work duties and hours without the need for any time off from work or change to how work is completed (without any need for absences related to continued appointments, treatment, care, or recovery)

   ☐ Yes, the employee may access all work benefits **without the need for any accommodation.**

   ☐ Yes, the employee may complete all essential job functions **without any change to the manner of work** (i.e. without any need for the use of crutches, elevating or icing recovering body parts, and without any limits to functional work activities such as lifting, climbing, or any physical, emotional, or mental work requirement)

2. **If you cannot answer each of the questions above in the affirmative, please continue to page 2:** ***Return to Work Modified Duty Request***

3. **Return to Full Duties Release Date:** _____

_____ _____

SIGNATURE OF HEALTH CARE PROVIDER **DATE**

PRINTED NAME OF HEALTH CARE PROVIDER:_____

TYPE OF HEALTH CARE PROVIDER:_____ LICENSE #_____

ADDRESS:_____ CITY:_____ STATE:____ ZIP CODE:_____

Return to Modified Duty Request

Employee Information	
Employee Name:	Patient's Name *(if other than employee)*:
Health Care Provider Name:	Relationship of Employee to Patient:
Employee's Job Title:	Personal Phone & Email:

Health Care Provider Section

1. Please indicate which, if any, of the categories listed on page 3 describe this patient's **"serious health condition"** and note the **probable duration of the condition.**

☐ **A.** inpatient care in a hospital, hospice, or residential health care facility

☐ **B**. continuing treatment or continuing supervision by a health care provider

Probable duration of the condition:_____

IF THE EMPLOYEE IS THE PATIENT:

2. Is the employee able to perform the essential functions of his/her job? ____Yes ____No *(See job description)*

Is the employee able to work a reduced work schedule and/or require other accommodations? ___Yes ____No

If yes, please describe nature of work restrictions:_____

_____ Likely Duration:_____

IF A FAMILY MEMBER IS THE PATIENT:

3. Is the employee's presence necessary to provide on-site care for the patient? ___Yes ____No
Is the employee's presence deemed beneficial to the welfare of the patient? ___Yes ____No
Does the patient require full-time care? ___Yes ____No
If no, please describe probable duration:_____

ANSWER THE FOLLOWING ONLY IF THE EMPLOYEE IS ASKING FOR INTERMITTENT LEAVE OR A REDUCED WORK SCHEDULE.

4. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule due to the condition (including treatment)? *If yes, please describe the probable duration*
___Yes, probable duration:_____ ____No

5. **A.** If the condition is **chronic** (#4), is the patient presently incapacitated? ___Yes ____No

B. If the condition will cause **episodic flare ups of incapacity** preventing the employee from performing his/her job functions, please indicate the **likely duration and frequency of periodic episodes of incapacity:**

Frequency: _____ times per_____ (wk. or mo.) **Duration: _____hours _____day(s) per event**

6. If the patient will be absent from work or other daily activities because of **treatment on an intermittent or part-time basis**, provide an estimate of the probable frequency rate and intervals between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

Probable number of treatments: _____ **Actual or estimated dates of treatment:** _____

Period required for recovery (if any): _____ **Interval between treatments:** _____

_____ _____

SIGNATURE OF HEALTH CARE PROVIDER **DATE**

PRINTED NAME OF HEALTH CARE PROVIDER:_____

TYPE OF HEALTH CARE PROVIDER:_____ LICENSE #_____

ADDRESS:_____ CITY:_____ STATE:____ ZIP CODE:_____

NOTICE TO HEALTH CARE PROVIDER

Under Department of Labor regulations for the Family and Medical Leave Act and the State of California Family Rights Act, "health care provider" is defined as: a doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices; a podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, clinical social worker, or physician assistant who is authorized to practice by the State and performing within the scope of his or her practice as defined by State law; a Christian Science practitioner listed with the First Church of Christ, Scientist, in Boston, Massachusetts; or any health care provider from whom the employer of the employee's group health plan benefits manager will accept a medical certification to substantiate a claim for benefits.

The employee has requested leave under the provisions of Federal and/or California family and medical leave statutes for:

- His or her own serious health condition; or
- For the purpose of caring for your patient who is a parent (biological, foster or adoptive parent; parent-in-law, stepparent; a legal guardian; or other person who stood in loco parentis to the employee when the employee was a child), a child (biological, adopted or foster child; a stepchild; a legal ward; a child of a domestic partner, child for whom the employee is standing in loco parentis to; domestic partner, or spouse (a husband or wife as defined or recognized under State law for purposes of marriage, including common law marriage in states where it is recognized), sibling, grandchild, or grandparent of our employee.

In order for the employer to determine whether this leave qualifies for family and medical leave under Federal and/or State law, please **complete the brief Health Care provider section on page 2 this form and return it to our employee.**

Serious Health Condition Categories:

"Serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either:
(A) inpatient care in a hospital, hospice, or residential health care facility; or
(B) continuing treatment or continuing supervision by a health care provider.

A serious health condition generally is not:

- Allergies, stress, or substance abuse unless inpatient hospital care is required, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term condition; or
- Voluntary treatment or surgery (unless inpatient hospital care is required.)

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.

DO NOT DISCLOSE THE UNDERLYING DIAGNOSIS

These documents are available in Word format. If you would like to receive Word documents, please email HR Advisor Annie Kavanagh at akavanagh@rgs.ca.gov and request them. Thank you!