



CERTIFICATE OF HEALTH CARE PROVIDER

INSTRUCTIONS FOR EMPLOYEE: PLEASE FILL OUT THE EMPLOYEE PORTION, THEN FORWARD TO YOUR OR YOUR FAMILY MEMBER'S HEALTHCARE PROVIDER TO COMPLETE AND SIGN. THIS FORM MUST BE SUBMITTED NO LATER THAN 30 DAYS PRIOR TO YOUR REQUESTED LEAVE DATE, OR IMMEDIATELY FOR UNFORESEEABLE LEAVES.

EMPLOYEE	Employee:	
	Patient (if other than employee):	Relation to employee:
	Begin date of requested leave:	End date of requested leave:
	If intermittent or reduced schedule is requested, please indicate requested schedule:	
	Signature: _____ Date: _____	

HEALTH CARE PROVIDER: PLEASE FILL OUT THE FOLLOWING INFORMATION

HEALTH CARE PROVIDER	<i>IF LEAVE IS DUE TO EMPLOYEE'S SERIOUS HEALTH CONDITION</i>	
	Does this employee have a serious health condition? (See reverse side for definition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
	When did the serious health condition begin?	
	Please review the attached job description. Is this employee able to perform the functions of his or her job? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If intermittent leave or a reduced work schedule is being considered, is it medically necessary? <input type="checkbox"/> *Yes <input type="checkbox"/> No	
	* If yes , please describe the recommended schedule:	
	What is the begin date of the leave?	What is the anticipated return to work date?
	<i>IF LEAVE IS DUE TO SERIOUS HEALTH CONDITION OF EMPLOYEE'S FAMILY MEMBER</i>	
Does employee's family member have a serious health condition? (See reverse side for definition) <input type="checkbox"/> Yes <input type="checkbox"/> No		
When did the serious health condition begin?		
Is the employee's presence necessary or would it be beneficial to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No (This may include psychological comfort and/or arranging for third-party care for the family member.)		
If intermittent leave or a reduced work schedule is being considered, is it medically necessary? <input type="checkbox"/> *Yes <input type="checkbox"/> No		
* If yes , please describe the recommended schedule:		
What is the begin date of the leave?	What is the anticipated return to work date?	
<i>HEALTH CARE PROVIDER INFORMATION</i>		
Name of Health Care Provider:		
Specialty:		
Address of Health Care Provider:		
_____ *Signature of Health Care Provider	_____ Date	
Place stamp here		
<small>* Department of Labor regulations for the Family and Medical Leave Act doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.</small>		

Dear Health Care Provider:

Our 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, child, or spouse of our employee).

In order for the District to determine whether this leave qualifies for family and medical leave under District policy and Federal and/or State law, **please complete the brief Certificate of Health Care Provider on the reverse side of this letter and return via fax to:**

**Human Resources
San Bernardino Community College District
Fax: 909-382-0173**

Or via mail to:

Human Resources
San Bernardino Community College District
114 S. Del Rosa Dr.
San Bernardino, CA 92408

Do not release the employee's diagnosis unless authorized by the employee (see "Employee Section" of this form for authorization).

If you have any questions, please phone 909-382-4040. Thank you for your assistance.

A serious health condition is

any illness, injury, impairment or physical or mental condition that involves:

- any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or
- continuing treatment by a health care provider for one or more of the following:
 - any period of incapacity for more than three consecutive calendar days that also involves treatment two or more times or treatment on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.
 - any period of incapacity due to pregnancy, for prenatal care.
 - any period of incapacity due to a chronic serious health condition that:
 - requires periodic visits for treatment;
 - continues over an extended period of time; and
 - may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
 - any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease).
 - any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition such as cancer or kidney disease.

A serious health condition 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 health condition; or
- voluntary treatment or surgery unless inpatient hospital care is required.

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner. A health care provider also is any provider from whom the University or the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.