Health Care Provider Certification Form
(Leaves of Absence)

GROSSMONT-CUYAMACA COMMUNITY COLLEGE DISTRICT

Section II. Health Care Provider begins on Page 2.

Section I. To be completed by the Employee.

Employee's Work Location: District Offices ☐ Grossmont ☐ Cuyamaca ☐

Name of Employee: _____

Employee's Job Title: _____ Regular Work Schedule: _____

Employee's essential job functions: _____

_____

EMPLOYEE – Please indicate the type of leave you are requesting:

☐	CFRA – Child Bonding Leave	☐	Medical Leave – Family (Non-FMLA)
☐	FMLA / CFRA – Medical Leave – Self	☐	Medical Leave – Self (Non-FMLA)
☐	FMLA / CFRA – Family Care Giver	☐	FMLA – Pregnancy Leave
☐	FMLA – Military Care Giver	☐	FMLA – Military Exigency
☐	PDL - Pregnancy Disability Leave	☐	Pregnancy Leave (Non-FMLA)

EMPLOYEE – Please identify the person for whom the leave is relevant:

Please indicate if this leave is requested for employee's **self** ☐ or to care for a **family member** ☐

Name of the **Family Member** for whom you will provide care: _____

Relationship of the family member: _____

Birthdate of the family member: _____

Describe the care you will provide for your family member including the frequency of care:_____

_____

_____

_____ _____

Signature of Employee **Date**

Section II. To be completed by the Health Care Provider.

HEALTH CARE PROVIDER

The employee listed above has requested leave for their **self** or to provide care for their **family member**. Please answer, fully and completely, all applicable parts for your patient below.

Please be sure to sign the form on the last page.

Part A: Medical Facts

1. Approximate date condition commenced: _____
2. Probable duration of condition: _____
3. Date(s) you treated the patient for the condition: _____
4. Will the patient require follow-up/treatment visits? **Yes**___ **No**___ If yes, please identify the frequency _____ and duration _____ . Describe any care needed for the patient by their family member: _____
   _____
5. Is the medical condition pregnancy? **Yes**___ **No**___. If so, expected delivery date: _____
6. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment or recovery? **Yes**___ **No**___.
   If yes, estimate the beginning _____ and ending dates _____ for the period of incapacity:
7. Will the patient require care on an intermittent basis, including any time for recovery? **Yes**___ **No**___. If yes, estimate the hours the patient needs care on an intermittent basis:

   _____ Hour(s) per day; _____ day(s) per week; from _____ through _____

Part B: Amount of Leave Needed (For Employees)

8. Is the **employee** unable to perform any of their job functions due to this condition? Yes___ No___.
   (Please use Section I on page 1 to identify the employee's essential job functions.)

If so, identify the job functions the **employee** is unable to perform: _____

_____

_____

Specifically identify any accommodations needed by the **employee** due to this condition: _____

_____

If a reduced work schedule is needed, indicate the following:

_____ Hour(s) per day; _____ day(s) per week; **from** _____ through _____

9. Will the condition cause episodic flare-ups periodically preventing the **employee** from performing his/her job functions? **Yes**___ **No**___ If yes, is it medically necessary for the employee to be absent from work during the flare-ups? **Yes**___ **No**___

10. ADDITIONAL INFORMATION: (Identify the question number with your response below.) _____

_____

_____

_____

_____

_____

_____

_____

PROVIDER'S name and business address: _____

Type of Practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

_____ _____

Signature of Health Care Provider **Date**