City of Milpitas
Human Resources Department
455 E. Calaveras Blvd., Milpitas, CA 95035
(408) 586-3090, FAX: (408) 586-3092 TDD # (408) 586-3013

Family and Medical Care Leave (FMLA)
California Family Rights Act (CFRA)

Physician Certification
Serious Health Condition – Family Member

TO BE COMPLETED BY EMPLOYEE

Employee Name:
State the care you will provide your family member suffering from a serious health condition.
Provide 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 leave schedule.
Employee Signature: Date:

TO BE COMPLETED BY PHYSICIAN

Patient's Name: _____

Indicate "yes" or "no" as to whether a serious health condition exists for the above named employee's family member.

- ☐ Yes ☐ No

- Serious health conditions are defined as follows:
  - Any period of incapacity or treatment in connection with a hospital, hospice or residential medical care facility;
  - Any period of incapacity requiring absence from work, school, or regular daily activities of more than three calendar days, that also involves continuing treatment by (or under the supervision of) a health care provider;
  - Continuing treatment by a health care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days;
  - Prenatal care.

Date condition began:	Probable duration of condition:

Continued on Back

Schedule of treatment:

Indicate number of visits, duration of treatment, including referrals to other providers of health services.

Number of Visits: _____

Duration of Treatment:
_____
_____
_____

Referral to other Health Services: Yes _____ No_____

Treatment Type: _____

Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.

Will Employee be off:

Full time: _____

Part-time: _____

If part-time indicate schedule:
_____
_____
_____

❑ Yes	❑ No	Is inpatient hospitalization of the family member required?
❑ Yes	❑ No	Does or will the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?
❑ Yes	❑ No	After review the of the employee's signed statement above, is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
Estimate period of time care is needed or the employee's presence would be beneficial:		
Signature of physician:		
Date:		

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Please fax back to our CONFIDENTIAL Human Resources fax at (408) 586-3092 or return in the self-addressed envelope attached.