CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(Family and Medical Leave Act of 1993/California Family Rights Act of 1993)

Return to:

Personnel Office
California Lutheran University
60 W. Olsen Rd.
Thousand Oaks, CA 91360

1. Employee's Name:

2. Patient's Name (If other than employee):

3. Date condition commenced:

4. Probable duration of condition:

5. Regimen of treatment to be prescribed. (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. 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.):
   a. By Physician or Practitioner:

   b. By another provider of health services, if referred by Physician or Practitioner:

IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 6,7, AND 8 AND PROCEED TO ITEMS 9 THROUGH 13 ON NEXT PAGE. OTHERWISE, CONTINUE BELOW.

Check Yes or No in the boxes below, as appropriate.

	YES	NO	
6.	☐	☐	Is inpatient hospitalization of the employee required?
7.	☐	☐	Is employee able to perform the 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.)

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEMS 9 THROUGH 14 BELOW AS THEY APPLY TO THE FAMILY MEMBER AND PROCEED TO ITEM 14 ON NEXT PAGE.

	YES	NO	
9.	☐	☐	Is inpatient hospitalization of the family member (patient) required?
10.	☐	☐	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
11.	☐	☐	After review of the employee's signed statement (See Item 13 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)

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

ITEM 13 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE

13. When Family Leave is needed to care for a seriously ill family member, the employee shall state the care he or she 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 leave schedule:

EMPLOYEE SIGNATURE:_____

DATE:_____

14. **PHYSICIAN OR PRACTITIONER SIGNATURE**:_____

15. **DATE:**_____

16. **TYPE OF PRACTICE (**Field of Specialization, if any**):**_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____ (Health care provider) to release the medical information set forth in the Certification of Physician or Practitioner relating to _____(patient) to **California Lutheran University** (employer).

This information is limited to being used in conjunction with the request by _____ for a Leave of Absence under the Family and Medical Leave Act and California Family Rights Act.

This authorization shall remain valid only until _____.

I understand that I have the right to receive a true copy of this authorization. By placing my initials to the left of this clause on the original authorization, I hereby acknowledge that a true copy of this authorization has been received.

_____ _____

(DATE) **(SIGNATURE)**