# UCSC LEAVE OF ABSENCE
# MEDICAL CERTIFICATION

**TO BE COMPLETED BY EMPLOYEE/SERVICE CENTER**

| | |
|---|---|
| Employee name: | Employee signature: |
| Patient (if other than employee): | Relation to employee: |
| Begin date of requested leave: | End date of requested leave: |
| Service Center contact: | Service Center phone number: |
| Service Center mailing address: | Service Center FAX number: |

**TO BE COMPLETED BY THE HEALTH CARE PROVIDER**
Please complete the following and return directly to the service center contact listed above

Section A: COMPLETE IF LEAVE IS BECAUSE OF EMPLOYEE'S SERIOUS HEALTH CONDITION

| | | |
|---|---|---|
| Does this employee have a serious health condition? (See reverse side for definition) | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No |
| What is the employee's anticipated return to work date? | | |
| If intermittent leave or a reduced work schedule is being considered, is it medically necessary?<br>If so, please describe the recommended schedule. | ☐ Yes | ☐ No |

Section B: COMPLETE IF LEAVE IS BECAUSE OF THE SERIOUS HEALTH CONDITION OF EMPLOYEE'S FAMILY MEMBER

| | | |
|---|---|---|
| Does employee's family member have a serious health condition? (see reverse side for definition) | ☐ Yes | ☐ No |
| When did the serious health condition begin? | | |
| Is the employee's presence necessary or would it be beneficial to the patient? (This may include psychological comfort and/or arranging for third party care for the family member) | ☐ Yes | ☐ No |
| What is the anticipated return to work date? | | |
| If intermittent leave or a reduced work schedule is being considered, is it medically necessary?<br>If so, please describe the recommended schedule: | ☐ Yes | ☐ No |

Section C: COMPLETE FOR ALL LEAVES

Name of Health Care Provider:

Specialty:

Address of Health Care Provider:

| | |
|---|---|
| Signature of Health Care Provider ______________ Date ______________ | Place Address Stamp Here |

RTN: 3 years (Note: medical information must be retained in a separate confidential file)

*This form is available on the web at http://www2.ucsc.edu/staff_hr/compensation/forms/medcert.pdf*

## Dear Health Care Provider

Our employee has requested leave under the provisions of Federal and/or California family and medical leave statutes, and/or the UCSC Catastrophic Leave policy and/or has requested other leave for medical reasons due to:

- 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 University to determine whether this leave qualifies for family and medical leave under Federal and/or State law, or as UCSC Catastrophic Leave, or as other leave for medical reasons, please complete the brief Health Care Provider section on the reverse side of this letter.

If you have any questions, please phone the service center contact listed on the reverse side. Thank you for your assistance.

### A serious health condition is:

- 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 or 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 (limited to the treatment of the spine to correct a subluxation as demonstrated by x-ray to exist), 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.