City of Hemet
Request for Family, Medical, and/or Pregnancy Disability Leave

PLEASE PRINT OR TYPE

Name: _____

Home address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

Department: _____ Supervisor's name: _____

I request family, medical, or pregnancy disability leave beginning: _____ and continuing through: _____

I request leave for the following purpose:

☐ The birth of my child or the placement of a child with me for adoption or foster care.

☐ A pregnancy-related disability (*note that this may also qualify as a serious health condition*).

☐ A serious health condition that makes me unable to perform the essential functions of my job.

☐ A serious health condition affecting my spouse, domestic partner, child, or parent for which I am needed to provide care.

Do you anticipate requiring leave on an intermittent or reduced schedule basis? ☐ Yes ☐ No
If yes, please explain: _____

Have you taken leave for any of these purposes within the past 12 months? ☐ Yes ☐ No
If yes, please give dates: _____

Total hours or days of anticipated absence from work _____

Family, medical, and pregnancy disability leaves are unpaid. If you wish to supplement your otherwise unpaid family medical, and pregnancy disability leave, indicate below which of your accumulated leaves you would like to use. Depending on the type of leave, the City may require the use of some paid leaves.

☐ Sick ☐ Vacation ☐ Administrative ☐ Compensatory ☐ Holiday

The use of your paid leaves does not extend the amount of leave to which you are entitled. All selected leaves will run concurrently with FMLA/CFRA/PDL Leave except for Compensatory Time Off.

Please note that leave taken for any of the above reasons applies toward the twelve weeks of eligibility for leave provided in the FMLA and CFRA. Leave taken for pregnancy-related disabilities applies toward the four months of eligibility for leave provided in the PDL.

I understand:
*** That I am required to provide certification of a health care provider of my illness or the illness of my immediate family member on a form provided by the City.**
*** That I will be required to provide a medical release upon my return to work.**

_____
Employee Signature **Date**

City of Hemet
Family, Medical, or Pregnancy Disability Leave
Certification of Health Care Provider

1. Employee's Name: _____

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

3. Relationship to Employee (check one) ☐ Spouse/Domestic Partner ☐ Child ☐ Parent

4. Date medical condition or need for treatment commenced **[NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT]**: _____

   _____

5. Probable duration of the medical condition or need for treatment: _____

   _____

6. The attached sheet describes what is meant by a "serious health condition" under federal and state laws. Does the patient's condition qualify under any of the categories described? If so, please check the appropriate category:

   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

7. If the certification is for the serious health condition of the employee, please answer the following:

YES	NO	
☐	☐	Is the employee able to perform work of any kind? If "no", skip next question.
☐	☐	Is the employee unable to perform any one or more of the essential functions of the employee's position? (Answer after reviewing the statement from the employer of the essential functions of the employee's position, or, if none provided, after discussing with the employee.)

   Comments: _____

   _____

8. If the certification is for the care of the employee's family member, please answer the following:

YES	NO	
☐	☐	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?
☐	☐	After review of the employee's signed statement (see Item 10 below), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

   Comments: _____

   _____

9. Estimate the period of time care needed or during which the employee's presence would be beneficial: _____

Comments: _____

_____

10. Please answer the following question only if the employee is requesting intermittent leave or a reduced work schedule:

YES	NO	
☐	☐	Is it medically necessary for the employee to be on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member?

If yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either my health care provider or another provider of health services upon referral from the health care provider: _____

_____

_____

Comments: _____

_____

11. **TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY LEAVE:** When family care leave is needed to care for a seriously ill family member, the employee shall state the care he/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 work schedule: _____

_____

_____

_____

_____ _____

Health Care Provider's Name (PRINT) Employee's Name (PRINT)

_____ _____

Health Care Provider's Signature Employee's Signature

_____ _____

Date Date

_____

Health Care Provider's Phone Number

Meaning of "Serious Health Condition"

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care**
   Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**
   A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   a. Treatment two (2) ore more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; or

   b. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. **Pregnancy**
   Any period of incapacity due to pregnancy or for prenatal care. **[NOTE: AN EMPLOYEE'S OWN INCAPACITY DUE TO PREGNANCY IS COVERED AS A SERIOUS HEALTH CONDITION UNDER FMLA BUT NOT UNDER CFRA.]**

4. **Chronic Conditions Requiring Treatment**
   A chronic conditions which:

   a. Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   c. May cause episodic rather than a continuing period of incapacity (*e.g.* asthma, diabetes, epilepsy, etc.)

5. **Permanent Long-Term Conditions Requiring Supervision**
   A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**
   Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident, or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.); severe arthritis (physical therapy); kidney disease (dialysis); etc.