RADY CHILDREN'S HOSPITAL SAN DIEGO
MEDICAL CERTIFICATION OF PHYSICIAN OR HEALTH CARE PROFESSIONAL - EMPLOYEE NON-FMLA

Employee Name: _____ **Date:** _____

Employer Name and Contact: Sue L. Flores, Human Resources-LOA

Employer Address: 3020 Children's Way, San Diego, CA 92123

Employer Confidential Fax: 858-966-7834

==========

To Physician or Health Care Provider: Please promptly complete this form and fax it to my employer at the above confidential fax number. This information is necessary to determine my eligibility for leave. Please see footnote below before responding.[1]

1. What is the general nature, extent and severity of the employee's medical condition? (Please see footnote below before answering question.) _____

   _____

2. Does the employee's condition limit his/her ability to perform the essential functions of his/her job? (Please refer to the enclosed job description, or if none, the employee's description of his/her essential job functions). Yes ☐ No ☐

   If yes, please identify the essential functions the employee cannot perform and briefly describe how he/she is limited:

   _____

3. How long do you anticipate these limitations, if any, will last? _____ weeks / ____ months / ☐ unknown

   If unknown, when will you again be evaluating his/her condition? _____

4. Would a leave of absence, or additional leave of absence, allow the employee to recover sufficiently to perform the essential functions of his/her job upon return from leave? ☐ Yes ☐ No ☐ unknown

   If yes, please indicate the amount and type of leave needed:

   a. **Continuous Leave**. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition (including any time for treatment and recovery)? ☐ Yes ☐ No. If yes, estimate the beginning and end dates for the period of incapacity. _____

   b. **Intermittent Leave Only**. Is it medically necessary for the employee to be off work on an intermittent basis as a result of the serious health condition? ☐ Yes ☐ No. If yes, state the frequency and duration below:

      Frequency of episode: _____ times per ☐ _____ week(s) _____ ☐ month(s)
      Duration of episode: _____ hours or _____ days(s) per episode
      Duration of need for leave: _____ ☐ week(s) _____ ☐ month(s)

   c. **Reduced Schedule Leave**. Is it medically necessary for the employee to work on a part-time or reduced schedule as a result of the serious health condition? ☐ Yes ☐ No. If yes, please state the schedule below:

      _____ hour(s) per day; _____ days per week from _____ through _____

5. Is there any accommodation besides leave that would allow the employee to return to work now and perform the essential functions of his/her job or any other job? ☐ Yes ☐ No. If yes, please specify: _____

   _____

HEALTH CARE PROVIDER CERTIFICATION

I certify the information provided by me in this certification is true and correct.

Healthcare Provider's Signature: _____ **Date:** _____

Print Health Care Provider's Name: _____ **Specialty:** _____

Health Care Provider's License No.: _____ **Phone:** _____

Healthcare Provider's Address: _____

[1] Please do not provide a diagnosis, statement of medical cause or the details of the employee's condition or treatment. To comply with the Genetic Information Nondiscrimination Act of 2008 (GINA), do not provide genetic information in response to this request. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.