Berkeley Academic Personnel Office

Certification of Health Care Provider for Household Member's Serious Health Condition

Required for approval of Temporary Workload Modification (TWM) for Ladder rank faculty and L(P)SOE only

PURPOSE of FORM: The below-named employee of the University of California, Berkeley has requested modified work due to their health-related caregiving responsibilities for your patient. This medical certification form will enable the University to confirm that the patient has a serious health condition that requires caregiving. Section III must be fully completed by the health care provider.

INSTRUCTIONS to EMPLOYEE: Please complete and sign Section II before giving this form to your household member's health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request due to your household member's serious health condition. Failure to provide a complete and sufficient medical certification to the University may result in a delay or denial of your request.

This form should be completed and returned within 15 calendar days of the University's request for this information, or no later than_____. Approved by APO on _____.

If you cannot return the completed form within the stated deadline, please contact appolicy@berkely.edu with the reasons for the delay and the date when the certification will be provided. You may return the form by email (preferred) to appolicy@berkeley.edu, in person, or by mail. The mailing address is: Academic Personnel Office, 127 California Hall #1500, Berkeley, CA 94720-1500.

SECTION I: To be completed by THE UNIVERSITY

Employee's Name

Name of University Representative

University Representative Department Address	Telephone

SECTION II – To be completed by EMPLOYEE

Name of household member for whom you will provide care:

If household member is your child, date of birth:	Relationship of household member to you:

If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability?	☐ No ☐ Yes

(1) Will you provide care to a household member? If yes, estimate the duration of care.

(2) Are you requesting modified work?	☐ No ☐ Yes

If yes, please describe the modifications you are requesting:

SIGNATURE

EMPLOYEE SIGNATURE	DATE

APPROVED BY APO (Section II.2 modification is not valid until approved by APO):

APO SIGNATURE	DATE

SECTION III – To be completed by HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested a modification of work to provide care for your patient. Please answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "indefinite," "unknown," or "indeterminate" may not be sufficient to determine the appropriate modification. **Limit your responses to the condition for which the patient needs the employee's care.** Please be sure to sign and date the form on Page 3.

IMPORTANT: DO NOT DISCLOSE ANY UNDERLYING DIAGNOSIS WITHOUT THE PATIENT'S CONSENT.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. '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 an 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.

THE CALIFORNIA GENETIC INFORMATION NONDISCRIMINATION ACT OF 2011 (CalGINA): The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with CalGINA, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

PROVIDER'S NAME

BUSINESS ADDRESS

TELEPHONE	FAX

PART A: MEDICAL FACTS

(1) Approximate date condition commenced:

_____

Probable duration of condition:

From:_____To: _____

(2) Page 4 describes what is meant by a "serious health condition." Does the patient's condition qualify under any of the categories described? ☐ No ☐ Yes

If yes, which type of serious health condition listed on Page 4 applies:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

PART B: AMOUNT OF CARE NEEDED

When answering these questions, keep in mind that your patient's need for care by the employee seeking a work modification may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

(1) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

(2) Will the patient be incapacitated intermittently? If so, please characterize the likely amount of caregiving that may be required during the specified dates:

Estimate the beginning and ending dates for the period of incapacity:

Beginning Date: End Date:

During this time, does the patient's condition require health-related caregiving?	☐ No ☐ Yes

SIGNATURE

Signature of HEALTH CARE PROVIDER	Date

Serious Health Conditions

A "serious health condition" means an illness, injury (including, but not limited to, an on-the-job injury), impairment, or physical or mental condition that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse.

- Inpatient Care means a stay in a hospital, hospice, or residential health care facility, any subsequent treatment in connection with such inpatient care, or any period of incapacity. A person is considered an inpatient when a health care facility formally admits them to the facility with the expectation that they will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.
- Incapacity means the inability to work, attend school, or perform other regular daily activities due to a serious health condition, its treatment, or the recovery that it requires.
- Continuing Treatment means ongoing medical treatment or supervision by a health care provider.

A serious health condition involves one or more of the following:

1. **Inpatient Care (as defined above)**

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 or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provided, 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 (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

3. **Pregnancy (which is covered as a serious health condition under FMLA but not under CFRA)**

   A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.

4. **Chronic Conditions Requiring Treatment**

   A chronic condition that:

   (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 that is permanent or long-term due to a condition for which treatment may not be effective. The person must be under the continuing supervision of, 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), or kidney disease (dialysis).