CALIFORNIA STATE UNIVERSITY, LONG BEACH

OFFICE OF FACULTY AFFAIRS

Leave Certification for Faculty

Please complete and return this form to Faculty Affairs via one of the following methods:

US Mail:
Attn: Faculty Leaves, Office of Faculty Affairs
CSU Long Beach, MS 0118
1250 Bellflower Blvd.
Long Beach, CA 90840-0118

Fax: 562-985-1680
Attn: Faculty Affairs

Email: AA-facultyLOA@csulb.edu

Need help? Contact us at:
562-985-1742

Employee Name:

Employee ID: _____

Employee's Job Title: _____

Work Schedule: _____

Essential Job Functions	Primary professional responsibilities of instructional faculty include: teaching assigned courses, independent research and scholarship, and service to the University.

TO BE COMPLETED BY EMPLOYEE: You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA/CFRA or medical leave due to the conditions below. Failure to provide sufficient 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 our request for information. If you cannot return the completed form within that time, please contact Faculty Affairs via the methods described above.

Employee is requesting leave for:

- ☐ the employee's own serious health condition
- ☐ Birth/adoption of a child or placement of a foster child with employee
- ☐ a family member's serious health condition:
  - ☐ Spouse or domestic partner
  - ☐ Child (biological, step-child, adopted child, foster child, or legal ward): Age:_____
  - ☐ Parent (biological, adoptive, foster, or step-parent)

For care of a family member with a serious health condition, please describe the care you will provide and estimate the leave needed to provide the care:

_____

_____

_____

_____

_____ _____

Employee Signature *Date*

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient (our employee or their family member) has requested medical leave under FMLA and/or CFRA. Please answer all applicable parts on page 2 fully and completely. 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 you medical knowledge, experience, and examination of the employee. Be as specific as you can; terms such as "indefinite," "unknown," or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage. **Limit your responses to the condition for which the employee is seeking leave.**

Notice: 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 completing this form. 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 or an embryo lawfully held by and individual or family member receiving assistive reproductive services.

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Patient's Name: _____

Approx. date condition commenced: _____ Probable duration of condition: _____

Is the medical condition pregnancy? ☐ No ☐ Yes

If Yes, due date/delivery date: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes

If Yes, dates of admission: _____

Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

Was the patient referred to other health care providers for evaluation or treatment (e.g. physical therapist)? ☐ No ☐ Yes

If Yes, describe the nature and expected duration of the treatments: _____

Will the patient be incapacitated for a single, continuous period of time for treatment or recovery? ☐ No ☐ Yes

If Yes, describe the nature and expected duration of the incapacitation: _____

During this time will the patient need care? ☐ No ☐ Yes

If Yes, describe the care needed whether it is medically necessary: _____

Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes

If Yes, estimate treatment schedule, including dates and duration of follow-up appointments:

Will the patient require care on an intermittent basis or be subject to a condition which may cause episodic flare-ups which prevent the patient from participating in daily activities (including any time for recovery)? ☐ No ☐ Yes

If Yes, estimate the hours patient needs care on an intermittent basis or the frequency and duration of incapacity due to flare-ups: *(e.g. "once/wk for 3 hours" or "every 3 months lasting 1-2 days")*

Describe any other relevant medical facts related to the condition for which the patient needs care.

Medical Provider Information:

Provider Name: _____

Name of Practice: _____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ email: _____

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