University of California, Irvine

NOTICE TO HEALTH CARE PROVIDER
(Request for Catastrophic Leave Certification)

Under Department of Labor regulations a "health provider" is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife 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.

Our employee has requested a Catastrophic Leave for:

- his or her own serious health condition; or
- for the purpose of caring for your patient (e.g., spouse, child, parent, sibling, grandparent, grandchild, or individuals residing in the employee's household).

In order for the University to determine whether this leave qualifies for a Catastrophic Leave, please complete the brief **HEALTH CARE PROVIDER CERTIFICATION FORM** (attached).

A SERIOUS HEALTH CONDITION IS:

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves:

- Any period of incapacity or treatment connected with inpatient care (e.g., an overnight stay) in a hospital, hospice, or residential medical care facility; or
- A period of incapacity requiring absence of more than three calendar days from work, school, or other regular daily activities that also involve continuing treatment by (or under the supervision of) a licensed health care provider; or
- Any period of incapacity due to pregnancy, or for prenatal care; or
- Any period of incapacity (or treatment therefore) due to a chronic serious health condition (e.g., asthma, diabetes, epilepsy, etc.); or
- A period of incapacity that is permanent or long-term due to a condition for which treatment may be effective (e.g., Alzheimer's, stroke, terminal disease, etc.); or
- Any absence to receive multiple treatments (including any period of recovery) by, or referral by, a licensed health care provider for a condition that likely would result in incapacity of more than three consecutive days if left untreated (e.g., chemotherapy, physical therapy, dialysis, etc.).

NOTE: *DO NOT DISCLOSE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF PATIENT*

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.

UNIVERSITY OF CALIFORNIA, IRVINE
(CONFIDENTIAL)

HEALTH CARE PROVIDER CERTIFICATION FOR CATASTROPHIC LEAVE

Employee Name:

Patient (if other than employee):

Relationship of employee to patient:

Beginning date of leave:

What is the employee's anticipated return-to-work date?

Medical Status and Recommendations from Health Care Provider

Does this employee or patient have a serious health condition? (see definitions) ◯ Yes ◯ No

On what date did the serious health condition commence?

If leave is for the employee:

Is employee able to perform the functions of his/her job? ◯ Yes ◯ No

Questions regarding the employee's job duties may be addressed to the employee's supervisor.

Employee's Supervisor: Phone:

Does the employee require a reduced work schedule or other medical accommodations (s)? ◯ Yes ◯ No

If yes, describe:

If leave is for employee's family member:

Is the employee's presence necessary to provide on-site care for the patient? ◯ Yes ◯ No

Is the employee's presence deemed beneficial to the welfare of the patient? ◯ Yes ◯ No

Does the patient require full-time care? ◯ Yes ◯ No

If no, describe:

Health Care Provider Information

Health Care Provider Signature: Date:

Type of Health Care Provider (see definition):

Address: Phone:

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