Central California Child Development Services, Inc.
2250 Rockefeller Drive, Suite 1, P.O. Box 2540, Ceres, CA 95307
(209) 581-9000 Fax: (209) 581-9009

MEDICAL LEAVE CERTIFICATION

EMPLOYEE

Employee:	
Work location (center):	Position/Title:
Patient (if other than employee):	Relation to Employee:
Begin date of requested leave:	End date of requested leave:
If leave is for my own serious health condition, I authorize health care provider to provide my diagnosis:	
Signature:	Date

HEALTH CARE PROVIDER

IF LEAVE IS BECAUSE OF EMPLOYEE'S SERIOUS HEALTH CONDITION

Does this employee have a serious health condition? (See reverse side for definition)	_____Yes ____No
When did serious health condition begin?	
What is employee's diagnosis?	
Please review attached job description. Is the employee able to perform the functions of his or her job?	_____Yes ____No
If intermittent leave or a reduced work schedule is being considered, Is it medically necessary?	_____Yes ____No
If so, please describe the recommended schedule.	
What is the anticipated return to work date?	

IF LEAVE IS BECAUSE OF A SERIOUS HEALTH CONDITION OF EMPLOYEE'S FAMILY MEMBER

Does employee's family member have a serious health condition? (see reverse side for definition)	_____Yes ____No
When did serious health condition begin?	
Is the employee's presence necessary or would it be beneficial to the patient? (This may include psychological comfort and/or arranging for third-party care for the family member.)	_____Yes _____No
If intermittent leave or a reduced work schedule is being considered, is medically necessary?	_____Yes _____No
If so, please describe the recommended schedule.	
What is the anticipated return to work date?	
Name of Health Care Provider:	
Specialty:	
Address of Health Care Provider:	

_____ Signature of Health Care Provider Date	Place address stamp here

Dear Health Care Provider:

Our employee has requested a leave under the provisions of Federal and/or California family and medical leave statutes for:

- His or her own serious health condition; or
- For the purpose of care for your patient (who is a parent, child, or spouse of our employee).

In order for Central California Child Development Services Inc., to determine whether this leave qualifies for family and medical leave under Federal and/or State law, please complete the brief Health Care Provider section on the reverse side of this letter.

DO NOT RELEASE THE EMPLOYEE'S DIAGNOSIS UNLESS AUTHORIZED BY EMPLOYEE (SEE "EMPLOYEE" SECTION OF THIS FORM FOR AUTHORIZATION.

If you have any questions, please contact our Personnel Department at (209) 581-9000. Thank you for your assistance.

A serious health condition is:

Any illness, injury, impairment or physical or mental condition that involves:

- Any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or

- Continuing treatment by a health care provider for one or more of the following:

    - Any period of incapacity for more than three consecutive calendar days that also involves treatment two or more times, or treatment on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.
    - Any period incapacity due to pregnancy for prenatal care.
    - Any period of incapacity due to a chronic serious health condition that:
        - Requires periodic visits for treatment
        - Continues over an extended period of time; and
        - May cause episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.)
    - Any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g. Alzheimer's disease).
    - Any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition such as cancer or kidney disease.

A serious health condition is not:

- Allergies, stress, or substance abuse unless inpatient hospital care is required, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health condition; or

- Voluntary treatment or surgery unless inpatient hospital care is required.

DEPARTMENT OF LABOR REGULATIONS FOR THE FAMILY AND MEDICAL LEAVE ACT DEFINES A "HEALTH CARE PROVIDER" AS A DOCTOR OF MEDICINE OR OSTEOPATHY, PODIATRIST, DENTIST, CHIROPRACTOR, CLINICAL PHYSCOLOGIST, OPTOMETRIST, NURSE PRACTITIONER, NURSE MIDWIFE, OR CLINICAL SOCIAL WORKER 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. A HEALTH CARE PROVIDER ALSO IS ANY PROVIDER FROM WHOM CCCDS OR THE EMPLOYEE'S GROUP HEALTH PLAN WILL ACCEPT CERTIFICATION OF A SERIOUS HEALTH CONDITION TO SUBSTANTIATE A CLAIM FOR BENEFITS.