CHAPMAN UNIVERSITY
Human Resources
One University Drive
Orange, California 92866
www.chapman.edu/hr
(714) 997-6686 • Fax: (714) 997-6901

FAMILY AND MEDICAL LEAVE CERTIFICATION	
Employee Name:	
Patient (if other than employee)	
Relationship of employee to patient	
Supervisor:	Telephone:
Probable duration of need for treatment:	

Medical Status and Recommendation from Health Care Provider
Does this employee or patient have a serious health condition? *See reverse side* ❒ yes ❒ no *(Note: the health care provider is not to disclose the underlying diagnosis without the consent of the patient)*
Date medical condition or need for treatment commenced:

If the leave is for the employee:

Is the employee able to perform the functions of his/her job? ❒ yes ❒ no
Please answer after reviewing the employer's job description or, if none provided, after discussing with the employee.

Is the employee able to perform work of any kind? ❒ yes ❒ no
If yes, describe:

Can the employee work a reduced work schedule or work with other medical accommodation(s)? ❒ yes ❒ no
If yes, describe:

If the leave is for the employee's qualifying family member:

Is the employee's presence necessary to provide on-site care for the patient? ❒ yes ❒ no

Does the patient require full-time care? ❒ yes ❒ no
If no, describe:

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

Health Care Provider Information	
Health Care Provider Signature	Date
Address	Telephone

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NOTICE TO HEALTH CARE PROVIDER

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

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

In order for the University to determine whether this leave qualifies for family and medical leave under federal and/or state law, **please complete the brief Health Care Provider certification on the reverse side of this form and return it to our employee.**

A SERIOUS HEALTH CONDITION *IS*:

Any illness, injury, impairment or medical 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
- any period of incapacity requiring absence from work, school, or regular daily activities for more than three calendar days, that also involves continuing treatment; or
- continuing treatment for a chronic or long-term health care condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days; or
- prenatal care

Examples: heart attacks, heart conditions requiring heart bypass or valve operations, most cancers, back conditions requiring extensive therapy or surgical procedures, strokes, severe respiratory conditions, spinal injuries, appendicitis, pneumonia, emphysema, severe arthritis, severe nervous disorders, and injuries caused by serious accidents on/off the job.

A SERIOUS HEALTH CONDITION IS *NOT*:

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

Under the Department of Labor regulations for the Family and Medical Leave Act, "health care 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 of California and performing within the scope of practice as defined by state law, or a Christian Science practitioner.