Certification of Health Care Provider for Medical Leave

(Family and Medical Leave Act of 1993 and all related state leave laws)

Note: Here and elsewhere on this form, the information sought relates only to the condition for which the employee is seeking leave.

This section to be completed by the **Chevron Employee:**	
Employee Name:	Employer Name: **Chevron**
Supervisor Name:	Supervisor Phone Number:
Patient's Name:	Date of Birth:

Patient's relationship to employee: ☐ Self ☐ Child ☐ Parent ☐ Spouse[1] ☐ Other[2]

If Other, please describe relationship (e.g., registered domestic partner):

What is your current weekly work schedule?

Will intermittent leave be required?

☐ Yes (If Yes – Please indicate ONE of the following)

Hours or Days (Circle one) Per Week _____

Hours or Days (Circle one) Per Month _____

☐ No Please specify the period of time you are requiring leave?

From: Through: Anticipated Return to Work Date

If leave is requested for the care of a family member, please state the care you expect to provide and an estimate of the period during which care will be provided, including a schedule if the leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

By signing below, I certify that the above information is true and correct and authorize a health care provider representing my employer to contact my health care provider to verify, clarify, or authenticate the reason for my requested family or medical leave. I authorize the release of medical information for this purpose. Furthermore, I understand that the failure to promptly return to work at the end of my leave may be treated as a resignation unless an extension has been approved in writing by my employer.

Employee's Signature:	Date:

[1] Common Law Spouses are qualified in AL, CO, GA before 1/1/97, ID before 1/1/96, IA, KS, MT, OH, OK, PA, RI, SC, TX, UT and DC. Affidavit required.

[2] Additional family members and/or same sex domestic partner may not be covered by FMLA but may qualify under state laws and/or allowed under Company Policy.

ReedGroup The Medical Disability Advisor

This section to be completed by the **Health Care Provider:**

Patient Name:	Chevron Employee Name:
Relation to Chevron Employee:	Employer Name: **Chevron**

Note that a "**serious health condition**" ordinarily excludes, unless complications arise, the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease, etc. Please select the treatment/condition of your patient below:

☐ **A**. **Inpatient Care** (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[1] or subsequent treatment[2] in connection with or consequent to such inpatient care; or

☐ **B.** A period of incapacity[1] of **more than three consecutive full calendar days** (including any subsequent treatment[2] or period of incapacity relating to the same condition) that also involves:

☐ 1. **Treatment[2] two or more times** by a health care provider with a minimum of two visits within 30 days of the first day of incapacity. Please provide the dates of the visits _____; or

☐ 2. **Treatment[2] by a health care provider** on **at least one occasion** which results in a regimen of continuing treatment[3] under the supervision of a health care provider, by a nurse or physician's assistant under direct supervision of a healthcare provider, or by a provider of health care services (e.g., physical therapist) under the orders of, or on referral by, a healthcare provider.

☐ **C.** Any period of incapacity[1] due to **pregnancy** or for **prenatal care**.

☐ **D.** A **chronic condition** which:

1. Require at least two visits for treatment[2] by a health care provider per year, or by a nurse or physician's assistant under the direct supervision of a healthcare provider;
2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
3. May cause episodic rather than a continuing period of incapacity[1] (e.g., asthma, diabetes, epilepsy, etc.).

☐ **E.** A period of incapacity[1] which is **permanent or long-term** due to a condition for which treatment[2] may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider (e.g., Alzheimer's disease, a severe stroke, or the terminal stages of a disease).

☐ **F.** Any period of absence to receive multiple treatments[2] (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[1] for more than three consecutive calendar days in the absence of medical intervention or treatment[2]**, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), or kidney disease (dialysis).

☐ **G.** None of the above.

In your opinion, does the patient's condition qualify as a "**serious health condition**" as defined above (items A-F):

☐ **Yes** ☐ **No**

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): (do not complete if patient is a California resident):

[1] "Incapacity" is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof or recovery therefrom.

[2] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[3] Regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

This section to be completed by the **Health Care Provider:**

Date this condition commenced:

Please indicate the probable duration of this condition (and also the probable duration of the patient's present incapacity[1] if different):

Dates of hospitalization, if applicable:
Admission Date Discharge Date

Is the employee required to be absent from work due to the condition? ☐ Yes ☐ No

If Yes, please complete the following:

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

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

Answer the below questions based on the employee's description of his or her job functions:

Is the patient unable to perform any of his/her job functions ☐ Yes ☐ No

If so identify the job functions the employee is unable to perform. _____

Regular leave:

Is/Was it medically necessary for the employee to be absent from work for full days? ☐ Yes ☐ No

Provide the dates when employee was/will be required to be absent from work: _____

Intermittent/Reduced schedule: ☐ Yes ☐ No

If the patient will be absent from work or other daily activities because of **treatment**[2] on an **intermittent** or **part-time** basis, provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any.

How often will time off be needed? (1/month, 1/week, etc.) _____

How many hours per day or per week will the employee require off? _____

Please indicate if a regimen of continuing treatment[3] is required under your supervision: ☐ Yes ☐ No

Future office visits: ☐ Yes ☐ No Frequency _____ Length of Appointments _____

Therapy: ☐ Yes ☐ No Frequency: _____ Length of Appointments: _____

Will any of these treatments[2] be provided by another provider of health services (e.g., physical therapist)?
☐ Yes ☐ No
If Yes, please state the nature of the treatments[2]: _____

I certify that the information on this form is accurate and truthful to the best of my knowledge. I certify that I completed this form based on medical information and facts derived from my treatment or care of this patient.

Signature of Health Care Provider (sign and print name):		**Date**:
Type of Practice:	**Practice Address:**	**Phone Number (with area code):**

[1] Incapacity" is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof or recovery therefrom.
[2] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.
[3] Regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Appendix C to Part 825 – Notice to Employees Of Rights Under FMLA (WH Publication 1420)

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employees child after birth, or placement for adoption or foster care;
- To care for the employees spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employee's are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of a Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employee's must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employer's may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employee's must provide 30 days advance notice of the need to take FMLA leave when the need if foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provider a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against the employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. §2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R §825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
www.wagehour.dol.gov
U.S. Department of Labor | Employment Standards Administration | Wage and Hour Division