



Health Care Provider Certification for the San Francisco Family Friendly Workplace Ordinance

Request for a flexible or predictable work arrangement to care for your family member with a serious health condition

STEP 1:

If you have not already done so, please complete and submit your request for a flexible or predictable work arrangement in writing to the Stay at Work/Return to Work Team by completing the form on the [Guidance Document Library](#).

STEP 2:

Please review the Family Friendly Workplace Ordinance FAQs found on the [Guidance Document Library](#).

STEP 3:

If you're requesting time off to care for your child under 18 years old, your spouse or domestic partner, or your parent with a serious health condition, you may also be eligible for leave under the Family and Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA). Please call Sedgwick at 1-855-732-8217 to request a leave of absence. If applicable, this form will be provided to Sedgwick for FMLA/CFRA designation.

Note: if you are requesting a continual leave or an unplanned, intermittent leave, this is not the correct form to complete. Please complete the medical certification form provided in your leave of absence package by Sedgwick.

STEP 4:

Return this certification form to the Stay at Work/Return to Work Team within 21 calendar days of the date you submitted your request form. You will be notified if additional forms are required and/or if your forms are incomplete or insufficient.

Stay at Work/Return to Work Team Email
Internal: Accommodations-Req@pge.com
External: Accommodations-Req@pge.com

Stay at Work/Return to Work Team Confidential FAX
Internal: 459-6124
External: 1-925-459-6124

The Genetic Information Nondiscrimination Act of 2008

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 GINA and CalGINA, please DO NOT provide any genetic information when responding to this request for medical certification.** "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 of an embryo lawfully held by an individual or family member receiving assistive reproductive services. "Genetic information," as defined by CalGINA includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or race.

Additional information relating to FMLA/CFRA

If you are eligible and you are absent for a qualifying reason, FMLA/CFRA will run concurrently with approved time off under this Ordinance.

Pacific Gas and Electric Company (PG&E) uses a rolling 12-month calendar measured backward from the date any FMLA/CFRA is used to determine available entitlements. See below for an explanation of how this is applied.

PG&E uses a rolling back calendar to account for FMLA and CFRA absences during a defined period of time (i.e., rolling year, rolling month and rolling week). For example, if an employee is approved for an intermittent leave of absence with an estimated frequency and duration of three absences every 30 days, lasting up to one full day, Sedgwick will count back 30 days from the most recent absence using the rolling back method to determine how many absences have already been reported. Your available FMLA and CFRA entitlements will be determined by reviewing any FMLA/CFRA absences taken in the 12 months prior to each new absence reported.

If you know that there will be changes to the frequency and/or duration of the FMLA/CFRA absences as certified by your treating physician, it is your responsibility to contact Sedgwick as soon as practical and seek re-certification as appropriate.

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EMPLOYEE SECTION

1. Your family member's health care provider must complete all questions on this form.
2. Fax this completed form to the Interactive Discussion Team at 925-459-6124.
3. Medical release: By signing below, I certify all information is accurate. I authorize the Health Care Provider to complete this form and provide additional information to clarify the content of the form verbally or in writing, if necessary, to PG&E and Sedgwick. I understand I may be referred to other PG&E benefit programs to help me and/or my family benefit from all available PG&E-sponsored resources before, during and after the flexible and/or predictable work arrangement.

SECTION 1	
Employee Name _____	Personnel Number _____
Patient/Family Member's Name _____	Familial Relationship _____
Child's date of birth <i>(Required if child is under the age of 18)</i> _____	

HEALTH CARE PROVIDER SECTION (Answer ALL Questions)

SECTION 2	
Check the applicable area that describes the serious health condition of your patient. Serious Health Condition means an illness, injury, impairment, or physical or mental condition that involves either continuing treatment or inpatient care.	
Part 1A: Continuing Treatment or Continuing Supervision by a Health Care Provider:	
<input type="checkbox"/> Absence Plus Treatment	<input type="checkbox"/> Chronic Condition Requiring Treatment
<input type="checkbox"/> Pregnancy Disability	Estimated Date of Delivery _____
<input type="checkbox"/> Multiple Treatments (Non-chronic Conditions)	
<input type="checkbox"/> Permanent/Long-Term Conditions Requiring Supervision	
Part 1B: Inpatient Care in hospital, hospice or residential care facility:	
Hospital Admission Date _____	Hospital Discharge Date _____
When did this serious health condition commence? _____	

SECTION 3

Describe the caregiving needs of the patient due to their serious health condition:

Does (or will) the patient require assistance by the employee for basic medical, transportation, hygiene, nutritional or safety needs? Explain

Will the employee's presence provide psychological comfort and be beneficial to the patient or assist in the patient's recovery?

Other needs?

SECTION 4

All answers should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as possible. Terms such as "unknown" or "as needed" are not sufficient.

Is it medically necessary for the employee to miss work due to the patient's family member's serious health condition(s)? Yes No

The family member needs care for their serious health condition under the following reduced/ part-time schedule:

Planned dates of treatment, therapy, appointments, other caregiving: From _____ To _____

Caregiving is likely needed in the mornings, evenings or during the day? (Check one)

Caregiving will last _____ hour(s) per day; _____ day(s) every 7 days 30 days 365 days (Check one)

Caregiving schedule or planned treatment, therapy and/or appointments will likely occur on:

Sun Mon Tue Wed Thu Fri Sat

HEALTH CARE PROVIDER ACKNOWLEDGMENT (to be filled out by health care provider)

SECTION 5

Name

Date

Address

Phone

Fax

Signature

Specialty (MD, DO, RN, etc.)