CERTIFICATION OF HEALTH CARE PROVIDER FOR PATERNITY LEAVE
Family and Medical Leave Act of 1993 (FMLA)/California Family Rights Act of 1993 (CFRA)

Please complete this confidential form and return it to: Human Resources
5150 N Maple Ave M/S JA71 Fresno, CA 93740-8026 Phone: 559 278-2032 Fax: 559 278-4275

Employee Name: _____ HR Contact_____
(PRINT NAME) (NAME)

I am requesting time for bonding with my child under the FMLA/CFRA Program. I have completed the *California State University Family and Medical Leave (FMLA/CFRA) Notice and Request* form. I will provide Human Resources with a medical note or the certification below by the document deadline.

Employee Signature: _____ Date: _____

Request for Medical Note

Instructions: The Health Care Provider may complete this form in lieu of a medical note. If a medical note is provided, it **must** include the information below.

Patient's Name: _____

Due Date: _____

Period of Disability: _____

Signature of Health Care Provider: _____ Date: _____

Print Name of Health Care Provider _____Phone Number:_____

Business address _____ City/State/Zip_____

Type of Practice/Medical Specialty _____Fax Number:_____