City and County of San Francisco
Carol Isen
Human Resources Director

Department of Human Resources
Connecting People with Purpose
www.sfdhr.org

Verification Of Caregiving Responsibilities By Healthcare Provider Under The Family Friendly Workplace Ordinance (FFWO)

The information sought on this form **relates only to the family member's condition** for which the employee is requesting a flexible or predictable working arrangement under the Family Friendly Workplace Ordinance (FFWO). This form must be filled out by the healthcare provider overseeing the care of the family member.

Employee's Name: _____ Patient's Name: _____

Does the patient's condition(s) qualify under either of the categories described below? If so, check the applicable category:

A "serious health condition," for purposes of the FFWO, means an illness, injury, impairment, or physical or mental condition that involves one of the following:

- ☐ Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility; or
- ☐ Continuing treatment or continuing supervision by a healthcare provider.

Describe the medical facts supporting your verification, including a brief statement about how the medical facts meet the criteria of one of the above categories[1]:

_____

_____

_____

_____

The date, if known, on which the serious health condition commenced: _____

The probable duration of the condition: _____

An estimate of the frequency and duration of time the employee needs to provide care for the family member:

_____

_____

_____

_____

Certified: _____
Provider Name and Title

Provider Signature: _____Date: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Telephone: (____)_____

License #: _____

[1] This certification should not disclose the underlying diagnosis without the patient's consent