Exhibit B

CONTRA COSTA WATER DISTRICT
FAMILY AND MEDICAL LEAVE CERTIFICATION

9/96

This section to be completed by the employee:

Employee: _____

Patient (if other than employee): _____ Relation to employee: _____

Begin date of requested leave: _____ End date of requested leave: _____

Supervisor: _____ Telephone: _____

If leave is for own serious health condition, I authorize my health care provider to provide my diagnosis.

Signature: _____ Date: _____

This section to be completed by Health Care Provider
IF LEAVE IS A RESULT OF EMPLOYEE'S SERIOUS HEALTH CONDITION

Does this employee have a serious health condition? (see reverse side for definition) ❑ yes ❑ no

If authorized, what is employee's diagnosis? _____

When did serious health condition begin? _____

Please review the attached job description. Is this employee able to perform the functions of his or her job?
❑ yes ❑ no

If intermittent leave or a reduced work schedule is being considered, is it medically necessary?
❑ yes ❑ no

If so, please describe the recommended schedule.

What is the anticipated return to work date?

IF LEAVE IS A RESULT OF THE SERIOUS HEALTH CONDITION OF EMPLOYEE'S FAMILY MEMBER

Does employee's family member have a serious health condition? ❑ yes ❑ no

When did the serious health condition begin? _____

Is the employee's presence necessary or would it be beneficial to the patient? ❑ yes ❑ no
(This may include psychological comfort and/or arranging for third-party care for the family member.)

If intermittent leave or a reduced work schedule is being considered, is it medically necessary?
❑ yes ❑ no

What is the anticipated return to work date? _____

Name of Health Care Provider: _____

Specialty: _____

Address and Phone Number of Health Care Provider: _____

Place address stamp here.

_____ _____
Signature of Health Care Provider Date

Dear Health Care Provider:

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

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

In order for the District to determine whether this leave qualifies for family and medical leave under Federal and/or State law, please complete the brief Health Care Provider section on the reverse side of this letter.

Do not release employee's diagnosis unless authorized by the employee (see "Employee Section" of this form for authorization).

If you have questions, please phone the supervisor listed on the reverse side. Thank you for your assistance.

A serious health condition is

any illness, injury, impairment or physical or mental condition that involves any of the following:

- inpatient care in a hospital or other treatment facility and related treatment;
- continuing treatment by a health care provider and includes periods of incapacity of more than three consecutive calendar days related to the treatment;
- continuing treatment or supervision by a health care provider following periods of incapacity;
- any period of incapacity or treatment due to a chronic serious health condition such as severe asthma, diabetes, epilepsy, etc.;
- any period of absence to receive multiple treatments for post-accident or injury restorative surgery or for a condition that would result in a period of incapacity in the absence of medical treatment, such as chemotherapy or radiation treatments for cancer, or dialysis for kidney disease.

A serious health condition is not

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

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife or clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner. A health care provider also is any provider from whom the District or the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.

F AMIL Y AND MEDICAL LEA VE
RETURN TO WORK CERTIFICATION

9/96

This section to be completed by the employee:

Employee: _____

Employee's Department: _____

Department Contact: _____

Telephone Number : _____

This section to be completed by Health Care Provider
PLEASE COMPLETE THE FOLLOWING AND RETURN TO THE DEPARTMENT PRIOR TO THE RETURN TO WORK DATE:

Please review the attached job description. Is the employee able to perform all the functions of his or her job?

❑ yes ❑ no ❑ yes, with restrictions or accommodations

Please list any restrictions or accommodations which the department should consider:

Are the restrictions: ❑ Permanent ❑ Temporary, until (date): _____

Comments:

Employee is released to return to work effective (date): _____

Name of Health Care Provider: _____

Specialty: _____

Address:

Place address stamp here.

_____ _____

Signature of Health Care Provider Date