**CFRA Second Opinion Clarification Regarding Medical Certificate With Workers’ Compensation (CAA2209)**

Send Certified And Regular Mail

Certification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

NAME

ADDRESS

Dear NAME:

We received your CFRA Medical Certificate(s) indicating your need for leave under the California Family Rights Act (CFRA). However, the COMPANY has concerns regarding the medical certification as it relates to your current serious heath condition. On DATE, COMPANY requested you cure the Medical Certificate; however, you neither responded to our request nor did you indicate you were unable to provide the curing within the seven (7) day time frame [CUSTOMIZE IF THEY RESPONDED BUT STILL DID NOT CURE]. This issue is unrelated to any of your rights or benefits under the Workers’ Compensation regulations.

Medical restrictions included on the medical certification received on DATE, dated DATE are as follows::

* LIST RELEVANT INFORMATION/ LIST MEDICAL CERTIFICATE LEAVE GUIDELINES

COMPANY, as per our rights under the CFRA, is requiring you seek a second opinion. You have been scheduled for an appointment with the following health care provider for the purpose of obtaining a second opinion:

* DATE / TIME
* HEALTH CARE PROVIDER’S NAME, NUMBER, ADDRESS

Please contact me immediately if you need assistance in re-scheduling this appointment. Time is of the essence. You must provide the enclosed Medical Certificate confirming your on-going need for leave no later than DATE [15 CALENDAR DAYS FROM DATE OF THIS LETTER] in order for the CFRA leave of absence to continue to be approved. Timely submission of your medical certification will assure that COMPANY NAME has sufficient documentation to confirm your need for protection under CFRA.

COMPANY is responsible for the cost of the appointment and any fees associated with filling out the Medical Certificate. Although COMPANY is not responsible for time for travel or time spent at the appointment. We will reimburse you for reasonable out-of-pocket expenses upon your submission of appropriate receipts.

In the event the second opinion differs from your initial Health Care Provider’s Medical Certificate, the COMPANY or you may request a third opinion at COMPANY’s expense. This third opinion shall be final and binding.

**The third health care provider must be designated or approved jointly by the employer and the employee**. The employer and the employee must each act in good faith to attempt to reach agreement on who to select for the third opinion provider.

**Failure to participate in the second and/or third opinion appointments may result in denial of CFRA protected leave and may subject you to disciplinary action up to and including termination.**

An employee returning from a Workers’ Compensation leave has no greater right to reinstatement than if the employee had been continuously employed rather than on leave. For example, if the employee on Workers’ Compensation leave would have been laid off had he or she not gone on leave, or if the employee’s position has been eliminated or filled in order to avoid undermining COMPANY’s ability to operate safely and efficiently during the leave, and no equivalent or comparable positions are available, then the employee would not be entitled to reinstatement.

**Please remember you are solely responsible for providing on-going medical certificates indicating your need for a medical leave of absence until such time your Workers’ Compensation claim has closed.** Your current medical certificate expires on DATE.

We have enclosed the Medical Certificate you recently submitted and a new Medical Certificate for the second opinion. A current job description for the position of [NAME OF POSITION] is also enclosed. Review the original Medical Certificate with the Health Care Provider and discuss the job description.

If you have any questions about the Family and Medical Leave or other benefits, please contact:

Name: HR/MEDICAL LEAVE ADMINISTRATOR CONTACT

Phone: TELEPHONE #

Enclosures:

1. Medical Certification Form
2. California Family Rights pamphlet
3. California Family Rights Act (CFRA) Medical Certification form DATE [LIST ALL IF MULTIPLE]
4. Job Description [Title of Job Description]
5. Authorization for Release of Medical Information [IF NOT ALREADY OBTAINED]