**CFRA Third Opinion - Exceeding Medical Certificate -**

**Conflicting 1st and 2nd Opinion with Workers’ Compensation (CAA2213)**

Send Certified And Regular Mail

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

DATE

NAME

ADDRESS

Dear NAME:

We received your second opinion CFRA Medical Certificate(s) indicating your need for leave under the California Family Rights Act (CFRA) .

Per the medical certificate received on DATE, dated DATE, the following restrictions were listed:

* LIST RELEVANT INFORMATION/ LIST MEDICAL CERTIFICATE LEAVE GUIDELINES

This issue is unrelated to any of your rights or benefits under the Workers’ Compensation regulations.

However, the second opinion medical certificate that was received does not cure your usage or clarify our questions regarding the original medical certificate.

For the time period between DATE to DATE, your usage of CFRA leave has been DAYS, HOURS, WEEKS [LIST DAYS, HOURS, ETC USED], this is over your allowable leave by [AMOUNT].

**COMPANY is requiring you to get OR You are requesting [CHOOSE ONE] a third opinion.** **The third Health Care Provider must be designated or approved jointly by COMPANY and you, 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.

Here are three medical providers that you may choose from for the **third** opinion:

1. HEALTH CARE PROVIDER’S NAME, NUMBER, ADDRESS
2. HEALTH CARE PROVIDER’S NAME, NUMBER, ADDRESS
3. HEALTH CARE PROVIDER’S NAME, NUMBER, ADDRESS

Please contact one of the above Health Care Providers to schedule an appointment. **Contact me immediately if you need assistance in scheduling this appointment.** Time is of the essence. You must provide the enclosed medical certification no later than DATE [15 CALENDAR DAYS FROM DATE OF THIS LETTER] in order for the FMLA leave of absence to continue to be approved or confirm when you are scheduled to see your medical provider and will be submitting the certificate to the COMPANY. Timely submission of your medical certification will assure that COMPANY has sufficient documentation to confirm your need for protection under CFRA.

COMPANY is responsible for the cost of the visit and any fees associated with filling out the medical certificate. COMPANY is not responsible for time for travel or time spent at the appointment however, we will pay for reasonable out of pocket expenses upon your submission of appropriate receipts. This third opinion shall be final and binding.

**Failure to participate in the third opinion appointment may result in denial of CFRA protected leave and may subject you to disciplinary action up to and including termination. [USE THIS SENTENCE IF EMPLOYER REQUIRES THE THIRD OPINION] OR Failure to participate in the third opinion appointment will result in defaulting to the second health care opinion. [CHOOSE THIS IF EMPLOYEE REQUESTS THIRD OPINION]**

**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 most recent medical certificate you have recently turned dated, DATE, the opinion form the second Health Care Provider, a new medical certificate for the third opinion and a current job description for the position of NAME [NAME OF POSITION]. 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: NAME OF CONTACT AND TITLE

Phone: CONTACT INFORMATION

Enclosures:

1. California Family Rights pamphlet
2. California Family Rights Act (CFRA) Medical Certification form [Blank]
3. California Family Rights Act (CFRA) Medical Certification form DATE [LIST ALL IF MULTIPLE]
4. California Family Rights Act (CFRA) Medical Certification form [Health Care Provider’s Second Opinion]
5. Job Description [Title of Job Description]
6. Authorization for Release of Medical Information [IF NOT ALREADY OBTAINED]