

**Nurse Practitioner Certification
For Paid Family Leave Benefits**

This form must be completed, signed, dated and the following information provided:

- 1. Care Recipient Full Name**

- 2. Care Provider's Full Name**

- 3. Care Provider's Social Security Number**

Nurse Practitioners certifying Paid Family Leave claims for the serious health condition of the care provider's family member must comply with Section 2835.7 of the Business and Professions Code (BPC) and Section 2708 of the California Unemployment Insurance Code (CUIC). In order to determine the above named care provider's eligibility for benefits, the certifying Nurse Practitioner must complete and sign the following statement.

I _____, certify that I performed a
(Nurse Practitioner's Full Name) (Print)
 physical examination of the care recipient and that I collaborated with a physician and surgeon pursuant to the requirements of Section 2835.7(a)(2) of the BPC, prior to certifying the serious health condition of the above named care recipient.

I understand that I am signing this certification voluntarily and that the care provider's payment or eligibility for Paid Family Leave (PFL) benefits will be affected if I do not sign this certification.

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| Nurse Practitioner's Signature (Do Not Print) | License Number | Date Signed |
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