



Stanislaus County
CEO- Risk Management Division
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Certification of Health Care Provider for
Employee's Serious Health Condition
(Family and Medical Leave Act)

For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete this Section before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial from your FMLA request. 29 C.F.R. §§ 825.313. If you leave has previously been denied due to insufficient or no medical certification you will be given 15 calendar days to return this form to your department and Risk Management. 29 C.F.R. §§ 825.305(b).

Your name: _____
First Middle Last

Department: _____

Employee Signature

Date

For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTHCARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of the condition, treatment, etc. Your answer should be your best estimate based upon her medical knowledge, experience, and an examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Providers name and business address: _____

Type of practice / Medical specialty: _____

Telephone: () _____

Fax: () _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Marked below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? _____ No _____ Yes If so, dates of admission: _____

Date(s) you treated the patient per condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition?

_____ No _____ Yes

Was medication, other than over-the-counter medication, prescribed? _____ No _____ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? _____ No _____ Yes. If so, state the nature of such treatments and expected duration of treatment: _____

2. Is the medical condition pregnancy? _____ No _____ Yes If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of employee's essential functions or job description, answer these questions based upon the employee's and description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition?

_____ No _____ Yes

If so, identify the job functions that employee is unable to perform: _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatments such as the use of specialized equipment): _____

PART B: AMOUNT OF CARE NEEDED:

- 5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery, _____ No _____ Yes
- 6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? _____ No _____ Yes

If so, are the treatments or the reduced number of hours of work medically necessary?
_____ No _____ Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

- 7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? _____ No _____ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?
_____ No _____ Yes. If so, explain _____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

