Stanislaus County
CEO- Risk Management Division
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Medical Certification
Serious Health Condition
(Family & Medical Leave Act/
California Family Rights Act)
EMPLOYEE

EMPLOYEE: The FMLA/CFRA permits an employer to require that you submit a timely, complete and sufficient certification to support a request for FMLA/CFRA leave due to a qualifying serious health condition. **Physicians may call 525-5710 with questions.**

Employee: _____ Employee ID #: _____

Department: _____ Employee Job Title: _____

Signature of Employee: _____ Date: _____

I certify that the statements made by me are true and correct to the best of my knowledge.
An employee who fraudulently obtains or uses FMLA/CFRA leave from an employer is not protected by FMLA/CFRA's job restoration or maintenance of health benefits provisions. An employer has the burden of proving that the employee fraudulently obtained or used FMLA/CFRA leave.

TO BE COMPLETED BY HEALTH CARE PROVIDER

HEALTH CARE PROVIDER INSTRUCTIONS: Your patient has requested leave under the FMLA/CFRA. Your help is needed to determine if leave qualifies under FMLA/CFRA and to allow consideration of the employee's ability to work in a modified duty capacity. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please answer fully and completely; terms such as "lifetime," "unknown," or "indeterminate" are not sufficient to determine FMLA/CFRA eligibility. Please be sure to sign the form on the last page. **DO NOT DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE WRITTEN CONSENT OF THE PATIENT**:

1) A "Serious Health Condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following (please check all that apply):

☐ A. **Hospital Care** Date of Admission: _____
Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an "inpatient" when a heath care facility formally admits him or her to the facility with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

Note: If Prescription *(other than over the counter) for this condition is necessary* - Employee must review the County's Drug Free Workplace Policy to assure compliance.

☐ B. **Absence Plus Treatment** Date(s) you have treated this patient for this condition: _____
A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

i. ☐ Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; **or**

ii. ☐ Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

☐ C. **Chronic Conditions Requiring Treatment** Date(s) you have treated this patient for this condition: _____

A chronic condition which:

i. Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

ii. Continues over an extended period of time (including recurring episodes of a single underlying condition); **and**

iii. May cause episodic rather than a continuing period of incapacity requiring treatment or recovery (e.g., asthma, diabetes, epilepsy, etc.).

Anticipated number of episodic flare ups _____ per ☐ Week ☐ Month or ☐Year

(e.g., one episode every 3 months lasting 1-2 days)

☐ D. **Permanent/Long-term Conditions Requiring Supervision**

A period of incapacity, which is permanent or long-term due to a condition for which treatment may not be effective. The employee must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

☐ E. **Multiple Treatments (Non-Chronic Conditions)** Date(s) you have treated this patient for this condition: _____

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).

2) Date Current **Continuous** Leave Begins: _____ Date Expected Return to Work: _____

3) Date medical condition or need for treatment commenced. _____

4) Probable duration of medical condition or need for treatment or recovery:

_____Is employee able to perform work of any kind? ☐Yes☐No

If yes, does the employee have any medically necessary work preclusions or restrictions? If so, please identify below (restrictions should take in to consideration the employee's regular job duties and be specific as to physical, mental or medical limitations. The County's Job Task Analysis documents are available on line at http://www.stancounty.com/riskmgmt/risk-dm-jta-class-sub-main.shtm). The County may be able to reasonably accommodate any medically necessary work restrictions in an alternate job assignment. Is the need for work preclusions or restrictions permanent? ☐ Yes ☐ No ☐Unknown at this time.

Restrictions: _____

_____

_____

5) Is it medically necessary for the employee to miss work on an **INTERMITTENT** basis or requires a **REDUCED WORK SCHEDULE?**
*Employees Requesting Intermittent Leave must make a reasonable effort to schedule leave so as not to disrupt unduly the employer's operations. Leave for treatment – employee must give department **30 days advance notice** or as much time as practicable. (Certification for intermittent leave may not exceed 6 months* limited exceptions may apply)*

Date **Intermittent** Leave Begins: _____ Date Intermittent Leave Ends: _____

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: ____ time(s) per _____week(s) _____month(s) Duration: _____hour(s) or ____ day(s) per episode

Reduced Schedule Leave: Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee?

If yes, please indicate the part-time or reduced work schedule that is medically necessary:

___ hour(s) per day; ___days per week, from _____ through _____

Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: ____ time(s) per _____week(s) _____month(s) **Duration:** _____hour(s) or ____ day(s) per appointment/treatment

Note: Certification of Chiropractic Care is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray.

Name of Treating Heath Care Provider:	License #:	Phone:	Fax:
Business address:			
_____ Signature of Provider	_____ Date		

I certify that I am the physician providing care for the patient identified in this document and that the statements made by me are true and correct to the best of my knowledge.

IMPORTANT NOTE: *The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.*

Note: Authority cited: Section 12935(a), Government Code. Reference: Section 12945.2, Government Code; California Genetic Information Nondiscrimination Act, Stats. 2011, ch. 261; Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; and 29 C.F.R. § 825.