Stanislaus County
CEO- Risk Management Division
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Medical Certification (Family & Medical Leave Act/ California Family Rights Act) **FAMILY MEMBER**

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. **Physicians may call 525-5710 with questions.**

Employee: _____ Employee ID#: _____ Department: _____

Employee Requesting Leave Beginning: _____ Date Expected Return to Work: _____

Patient's Name: _____

Relationship to employee: ☐ spouse ☐ Registered Domestic Partner (CFRA) ☐ parent ☐ minor child ☐ adult child (*Care of Adult Dependent Child* **who is incapable of self-care because of a mental or physical disability within the meaning of Government Code section 12926(j) and (l)** *Requires active assistance or supervision in three or more activities of daily living (ADLs) or instrumental activities of daily living (IADLS).*
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 FAMILY MEMBER'S HEALTH CARE PROVIDER

PATIENT'S HEALTH CARE PROVIDER INSTRUCTIONS: Our employee has requested leave under the FMLA/CFRA to provide care for a family member. As the employer, we need your assistance to determine if our employee is eligible for FMLA/CFRA protected leave. Please answer fully and completely; terms such as "unknown," or "indeterminate" are not sufficient to determine FMLA/CFRA eligibility. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please be sure to sign the form on the last page. **DO NOT TO 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, impairment, or physical or mental condition that involves 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

☐B. **Absence Plus Treatment** Date(s) care provided 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) care provided 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 (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 or family member 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 or late stages of a disease.

☐E. **Multiple Treatments (Non-Chronic Conditions)** Date(s) care provided 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 medical condition or need for treatment commenced. _____

3) Probable duration of medical condition or need for treatment: _____

4) Does, or will the patient require assistance for basic medical, hygiene, nutritional needs, psychological comfort, safety or transportation?

☐Yes☐ No

5) Employee must provide a signed statement to the family member's physician listing the type of care he/she will be providing to his/her family member, with the information noted below. Did you receive a written and signed statement from our employee?
☐Yes☐ No

6) After review of the employee's signed statement, does the condition warrant the participation of the employee?

☐Yes☐ No *(This participation may include psychological comfort and/or arranging for third-party care for the family member.)*

7) Estimate the period of time care needed or during which the employee's presence would be beneficial: _____

_____

8) Please answer the following question only if the employee needs leave 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)*

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

Is it medically necessary for the employee to be off work on an **INTERMITTENT** basis or requires a **REDUCED WORK SCHEDULE** to care for the family member?
☐Yes☐ No

If yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider. _____
_____
_____

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: ____ times per _____week(s) _____month(s) Duration: _____hours 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's family member?

☐Yes☐ No

If yes, please indicate the part-time or reduced work schedule the employee needs:
___ 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?

☐Yes☐ No

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: ____ times per _____week(s) _____month(s) Duration: _____hours or ____ day(s) per appointment/treatment

EMPLOYEE NEEDING FAMILY LEAVE ****TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER.

10. When family care leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

_____

_____

Name of Treating Health 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.