Stanislaus County
CEO- Risk Management Division
1010 10th Street Suite 1400, Modesto, CA 95354
Phone 209-525-5715 Fax 209-525-5779

EMPLOYEE

Medical Certification Serious Health Condition
(Family & Medical Leave Act/ California Family Rights Act/Pregnancy Disability)

FMLA/CFRA/PDL permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA/CFRA/PDL leave due to a qualifying serious health condition. Physicians may call 525-5715 with questions.

Employee: _____ Employee ID #: _____ Department: _____
Employee Job Title: _____ Normal Work Schedule: _____
Type of Leave: ☐Continuous ☐Intermittent ☐Reduced Schedule Leave
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

Part A-Medical Information

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/PDL 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) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy).*
2) Provide your **best estimate** of how long the condition lasted or will last: _____
3) Check the box(es) for the questions below, as applicable. **For all box(es) checked, the amount of leave needed must be provided in Part B.**

☐ **Inpatient Care:** The patient (has been/ is expected to be) admitted for an overnight stay in the hospital, hospice, or residential medical care facility.

☐ **Incapacity Plus Treatment:** (e.g. outpatient surgery, strep throat) Due to the condition, the patient (has been/ is expected to be) incapacitated for more than three consecutive, calendar days.
The condition (☐has/☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication <other than over the counter> or therapy requiring special equipment).

☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____*(mm/dd/yyyy).*

☐ **Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent/Long-Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions Requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **Elective Medical Procedure**: (e.g. cosmetic procedures*, non-specific chiropractic care**, acne)
☐ Serious Medical Condition **IS** present. ☐ Serious Medical Condition **NOT** present.

***Note: Conditions for which cosmetic treatments** are administered (such as most treatments for acne or plastic surgery) are not serious health conditions unless inpatient hospital care is required, or complications arise.

****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.

☐ **None of the Above:** If none of the above condition(s) were checked, (e.g. inpatient care, pregnancy) no additional information is needed. Go to page 2 to sign and date form.

4) Due to the condition, the patient (was/ will be) referred to other health care provider(s) for evaluation or treatment(s). List other healthcare provider(s): (e.g. cardiologist, physical therapy): _____
_____

Part B-Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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. Be as specific as you can; terms such as "lifetime, unknown, or indeterminate" may not be sufficient to determine if the benefits and protections of FMLA apply.

CONTINUOUS:

Due to the condition, the patient (☐was/☐will be) incapacitated for a **continuous** period, including any time for treatment(s) and/or recovery. Provide your best estimate of the beginning date: _____ *(mm/dd/yyyy)* Returning on _____*(mm/dd/yyyy)* for the **continuous** period of incapacity.

INTERMITTENT:

Due to the condition it, (☐was/ ☐is /☐will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity (e.g. episodic flare-ups) or appointments. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity or appointments will likely last.

Starting on _____ (mm/dd/yyyy) Returning on_____ (mm/dd/yyyy) episodes of incapacity are estimated to occur _____ times per (☐day/☐week/☐month) and are likely to last _____ (☐hours/☐days) per episode or appointment.

REDUCED SCHEDULE:

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? ☐ Yes☐ No

If yes, please indicate the part-time or reduced work schedule the employee is allowed to work: _____ hours per day; _____ days per week from: _____ (mm/dd/yyyy) through: _____ (mm/dd/yyyy).

Part C-Essential Job Functions

Due to the condition, the employee (☐was not able /☐is not able /☐will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function the employee is not able to perform: _____
_____

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.

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

Employee Name: _____

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: • Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, • At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT: If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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.