Employee Name: _____

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

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 525-5715 with questions.

Employee: _____ Employee ID#: _____Department: _____
Employee Requesting Leave Beginning: _____ Expected Return to Work Date: _____
Employee's Normal Work Schedule: _____ Patient's Name: _____
Type of Leave: ☐Continuous ☐Intermittent ☐Reduced Schedule Leave
Relationship to Employee: ☐Spouse ☐Registered Domestic Partner (CFRA) ☐Parent ☐Minor Child ☐Grandparent (CFRA) ☐Grandchildren (CFRA) ☐Sibling (CFRA) ☐Child of Domestic Partner (CFRA) ☐Parent-in-law (CFRA) ☐Designated Person (CFRA-One designated person per 12-month period. CA AB 1041) ☐Adult Child (CFRA/FMLA*) **Care of Adult Dependent Child* **who is incapable of self-care because of a mental or physical disability within the meaning of Government Code s 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).*
Briefly describe the care you will provide to your family member (Check all that apply):
☐Assistance with basic medical, hygienic, nutritional, safety needs ☐Transportation ☐Physical Care ☐Psychological Comfort
☐Other: _____
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

Part A-Medical Information

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 DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE WRITTEN CONSENT OF THE PATIENT:**

1) Patient's Name: _____
2) Date medical condition or need for treatment commenced: _____*(mm/dd/yyyy).*
3) Probable duration of medical condition or need for treatment: _____
4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, psychological comfort): _____
_____
_____
5) Check (all) the box(es) for the question below, as applicable. For all box(es) checked the amount of leave must be provided in Part B.

☐ **Inpatient care:** The patient (☐has been/☐is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility. Date of Admission/Date Expected of Admission: _____*(mm/dd/yyyy).*

☐ **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, full calendar days from _____*(mm/dd/yyyy)* returning on _____*(mm/dd/yyyy)*. The patient (☐was/☐will be) seen for treatments on the following date(s): _____

The condition (☐has/☐has not) 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 or 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.

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

6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g. Use of nebulizer, dialysis): _____

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.

7) Due to the condition, the patient (☐had/☐will have) **planned medical treatment(s)** (scheduled medical visits e.g. psychotherapy, prenatal appointments) on the following date(s): _____

8) 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)* _____

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____

9) 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)* and return date _____ *(mm/dd/yyyy)* for the period of incapacity.

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

11) Due to the condition it, (☐was/☐is/☐will be) medically necessary for the employee to be absent from work to provide transportation to appointment(s) for the patient on an **intermittent basis** (periodically), including for any **episodes of incapacity** (e.g., medical appointments, treatments.) Provide your **best estimate** of how often (frequency) and how long (duration) the appointment(s) will likely last.

Starting on _____ *(mm/dd/yyyy)* Returning on_____ *(mm/dd/yyyy)* **medical appointment(s)** are estimated to occur_____ times per (☐day/☐ week/☐month) and are likely to last _____(☐hours/☐days) **per appointment.**

12) 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 **is allowed to work**: _____ hours per day; _____ days per week from _____ *(mm/dd/yyyy)* through _____ *(mm/dd/yyyy)*.

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 Health Care Provider:	License #:	Phone:	Fax:
Business address:			
_____ Signature of Provider	_____ Date		

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, • o 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.