# San Joaquin County: Health Care Provider's Certification Form (For Employee ONLY)

## Section I: to be completed by Employee

**INSTRUCTIONS to the EMPLOYEE**: Please complete Section I before giving this form to your medical provider. Failure to provide a complete and sufficient medical certification within **15 calendar** days from the date of this notice may result in a denial of or delay in the processing of your FMLA/CFRA request.

Your Name (Print): _____
First Middle Last

## Section II(a): to be completed by Health Care Provider

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA). Answer, fully and completely, all applicable parts. 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 FMLA/CFRA 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.

**1.** Patient's Name (Print) _____

**2.** Date on which health condition began: _____

**3.** A serious health condition is defined by the Family and Medical Leave Act as a physical or mental condition that involves one of the following categories:

**Please check the appropriate category that supports the serious health condition:**

**Note: Serious Health Conditions do not normally include:**

- common colds or the flu,
- minor ulcers or upset stomachs,
- headaches (but not migraines),
- earaches,
- routine dental or orthodontia problems,
- periodontal disease, or treatments that involve only over-the-counter medicines, bed rest, exercise, drinking fluids, and other activities that can be done without visiting a health care provider.

☐ inpatient care during an overnight stay in a hospital, hospice, or residential health care facility;

☐ prenatal care;

☐ pregnancy disability leave (a leave taken for disability due to pregnancy, childbirth, or related medical conditions);

☐ chronic conditions (e.g., asthma, diabetes, epilepsy, etc.) that (1) require periodic visits (at least twice a year) for treatment, (2) continue for a long time, and (3) may cause episodic rather than a continuing period of incapacity;

☐ incapacity for more than three consecutive days during which the patient is either (1) treated two or more times, or (2) treated and referred to a nurse, physician's assistant, physical therapist, or nurse practitioner for further treatment; or (3) treated and prescribed a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition;

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

Will the patient be scheduled for follow-up treatment visits for the condition? ☐ **No** ☐ **Yes**. If yes, date(s) _____

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 yes, state the nature of such treatments and expected duration of treatment:

_____

Was a course of therapy requiring special equipment to resolve or alleviate the health condition prescribed? ☐ **No** ☐ **Yes**.

****Note**: Any administrative costs associated with the completion of this form by the medical provider are the sole responsibility of the employee.

- ☐ permanent or long-term conditions that require continuing supervision, with or without active treatment (such as Alzheimer's, severe strokes, and the terminal stages of diseases);
- ☐ multiple treatments for either (1) restorative surgery after an injury, or (2) conditions likely to result in three day's incapacity if not treated (including chemotherapy, physical therapy for severe arthritis, and dialysis); or
- ☐ None of the above categories apply. Patient does not have a serious health condition as defined by FMLA.

**4.** Is employee unable to perform any one or more of the essential functions of his/her position? (*Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)* ☐ **No** ☐ **Yes**

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

_____

Probable Duration: From_____ To_____

**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**

If yes, estimate the beginning and ending dates for the period of incapacity: _____

## Section II(b): to be completed if employee requires intermittent leave or a reduced work schedule

**6.** Will the employee require follow-up treatment appointments or be off work on an intermittent basis or on a reduced schedule because of his/her medical condition? ☐ **No** ☐ **Yes**

If yes, 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 intermittent leave 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 preventing the employee from periodically 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 yes, 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) and **Duration:** _____ hours or ___ day(s) per episode

**(Print)** Health Care Provider's Name: _____ License No. _____

Type of Health Care Provider: _____ Telephone: (_____) _____

Address: _____
Street City State/Zip Code

**Health Care Provider's Signature:** _____ Date_____

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