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

San Joaquin County: Health Care Provider’s Certification Form (For Employee) (Page 2 of 2)

☐ 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 ________________________