MEDICAL CERTIFICATION – EMPLOYEE'S SERIOUS HEALTH CONDITION

SECTION I: For completion by the EMPLOYER

Employer's name and contact person: **County of Tuolumne/Human Resources**

Employee's job title: _____

Employee's regular work schedule: _____

Employee's essential job functions: **Please see attached job description.**

Check if job description is attached: ____

SECTION II: For completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA/CFRA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/CFRA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA/CFRA request. Your employer must give you at least 15 calendar days to return this form.

Your name: _____
First Middle Last

SECTION III: For completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA/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 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.

Provider's name and business address: _____

Type of practice/Medical specialty: _____

Telephone: (_____)_____

PART A: MEDICAL FACTS

[NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS]

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ❑ No ❑ Yes. If so, dates of admission:

   _____

   Mark below as applicable:
   If the patient was not admitted for an overnight stay in a hospital, hospice, or residential medical care facility, was the patient expected to remain overnight, even if the patient did not actually remain overnight?
   ❑ No ❑ Yes. If so, dates of expected admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition?
   ❑ No ❑ Yes

   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 so, state the expected duration of treatment (i.e. of each treatment session and how long the patient will be receiving such treatment):

   _____

2. Is the medical condition pregnancy? ❑ No ❑ Yes. If so, expected delivery date: _____

3. Is the employee able to perform work of any kind? ❑ No ❑ Yes.
   (If "No," skip next question.)

4. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition:
   ❑ No ❑ Yes

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

PART B: AMOUNT OF LEAVE NEEDED

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 so, estimate the beginning and ending dates for the period of incapacity:

   _____

6. Is it medically necessary for the employee to be off work on an intermittent basis due to the employee's serious health condition? ❑ No ❑ Yes

   Yes No

   ❑ ❑ **Intermittent Leave**: Is it medically necessary for the employee to be off work on an intermittent basis or to work a reduced number of hours of work in order to deal with his/her serious health condition?

   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

   Yes No

   ❑ ❑ **Reduced Schedule Leave**: Is it medically necessary for the employee to work less than the employee's normal work schedule due to his/her serious health condition?

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

   ___ hour(s) per day; ___ days per week, from _____ through _____

   Yes No

   ❑ ❑ **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?

   If yes, please indicate the estimated frequency of the employee's need 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

7. Will the condition cause episodic flare-ups periodically preventing the employee from 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 so, 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 last 1-2 days):

Frequency: _____ times per _____ week(s) _____ month (s)

Duration: _____hours or _____day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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_____ _____

SIGNATURE OF HEALTH CARE PROVIDER **DATE**

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.