Certification of Health Care Provider
Employee's Serious Health Condition

Human Resources Office – County of Yolo
Phone (530) 666-8055 – Fax (530) 666-8049

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CALIFORNIA FAMILY RIGHTS ACT (CFRA)

Part A: For Completion by the EMPLOYEE

Instructions to the Employee: Complete Part A before giving this form to your medical provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in denial of your leave request. **This form must be returned within 15 days of your FMLA/CFRA Notice of Eligibility.**

Employee Last Name	Employee First Name	Employee Middle Name	Last Day Worked

Department/Unit	Daytime Telephone Number	Regular Work Schedule:
		☐ Days ☐ Nights ☐ Full Time ☐ Part Time ☐ 9/80 ☐ 4/10 ☐ Other _____

Part B: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS for the HEALTH CARE PROVIDER: Your patient has requested leave under FMLA/CFRA. Please answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience and examination of the patient. Please be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): To comply with this law, we are asking that you not provide any genetic information as defined by GINA when responding to this request for medical information.

Please do not disclose the underlying diagnosis without the consent of your patient, and limit responses to the condition for which the employee is seeking leave.

Provider Name (You may attach a business card in lieu of completing this section)

Business Address	City	State	Zip Code

Type of Practice/Medical Specialty

Telephone	Fax

Signature below verifies that the information provided within is true and accurate.

Printed Name of Health Care Provider

_____
Health Care Provider Signature

Date

_____ _____

(rev 11/2020)

Employee Last Name	Employee First Name	Employee Middle Name

Part C: Medical Facts

1 Does the patient have a serious health condition that qualifies under the categories described on page 3 of this document? ☐ Yes ☐ No *If no, sign and date Page 1 and return to patient.*

If yes, please answer the following questions:

2. What is the approximate date that the condition commenced? _____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ☐ Yes ☐ No If yes, date of admission: _____
4. Dates treated for condition: _____
5. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ☐ Yes ☐ No If yes, state the frequency and expected duration of such treatments: _____
6. Is the employee unable to perform any of the job functions due to his/her medical condition? (Essential Job Functions and/or attached Job Description may be attached): ☐ Yes ☐ No
   If yes, identify the job functions the employee is unable to perform, work restrictions and probable duration:

7. Can the patient perform modified duty? ☐ Yes ☐ No
   If yes, state the type of modified duty the employee is able to perform and probable duration:

Part D: Amount of Time Needed

1. 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? ☐ Yes ☐ No
   If yes, estimate the period of incapacity. Begin Date: _____ End Date: _____

2. Will the employee need to attend follow-up treatment appointments because of the employee's medical condition? ☐ Yes ☐ No
   If yes, estimate the schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period _____

3. Will the employee need to work part time or on a reduced schedule because of the employee's medical condition?
   ☐ Yes ☐ No
   If yes, estimate the part-time or reduced work schedule the employee needs
   _____ hour(s) per day; _____days per week from_____ through_____

4. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No
   If yes, 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)
   Duration: _____ hours _____ day(s) per event

Definition of a Serious Health Condition:

Serious health condition is any illness, injury, impairment, physical or mental condition that involves:

1. Any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or
2. Continuing treatment by a health care provider for one or more of the following:
    a. Any period of incapacity due to pregnancy, for prenatal care (FMLA).
    b. Any period of incapacity due to a chronic serious health condition that:
        i. Requires periodic (at least two visit per year) visits for treatment
        ii. Continues over an extended period of time; and
        iii. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
3. Any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease)
4. Any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence or medical intervention such as cancer (chemotherapy, radiation, etc., or kidney disease (dialysis) or severe arthritis (physical therapy).

A Serious Health Condition Is Generally Not:

1. Allergies, stress, or substance abuse unless inpatient hospital care is provided, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health conditions; or
2 Voluntary treatment or surgery; inpatient hospital care is required.

A Health Care Provider Is:

Department of Labor regulations for the Family and Medical Leave Act define a “health care provider” as a

1. doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker, physicians assistant, who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.
2. any provider the County’s group health plan that the benefit manager will accept certification of a serious health condition to substantiate a claim for benefits.