Certification of Health Care Provider
Family Member's Serious Health Condition

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

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

Part A: For Completion by Employee

Instructions to the EMPLOYEE: Please Complete Part A before giving this form to your family member or his/her health care provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support a request for leave to care for a covered family member with a serious health condition. 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 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 _____

Relation to employee: ☐ Child/Child of Domestic Partner: *Child's date of birth* _____ ☐ Designated Person
☐ Spouse ☐ Parent ☐ Parent-in-Law ☐ Grandparent ☐ Grandchild ☐ Sibling ☐ Domestic Partner

Name of family member or person for who you will provide care:

Last Name First Name Middle Name

Describe the care you will provide to your family member and estimate how much time you will need to take to provide the care:

I certify that the information I have provided is true and correct.

_____ _____

Employee Signature Date

Part B: For Completion by the Health Care Provider

INSTRUCTIONS for the HEALTH CARE PROVIDER: The employee listed above has requested leave under FMLA/CFRA to care for your patient. 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 FLMA/CFRA coverage. **Please do not disclose the underlying diagnosis without the consent of your patient, and limit responses to the condition which the employee is seeking leave for the family member.**

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 sign and date the form on page 3**

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 4 of this document?
☐ Yes ☐ No *If no, sign and date Page 3 and return to patient.*
2. If yes, please answer the following:
   - Approximate Date Condition Commenced: _____
   - Probable Duration of Medical Condition or Need for Treatment:_____
3. Dates treated for condition: _____
4. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No
5. Was medication (other than over the counter) prescribed? ☐ Yes ☐ No
6. Does the condition of the patient warrant the participation of the employee? ☐ Yes ☐ No

Part D: Amount of Care Needed

When answering these questions, keep in mind the patient's need for care by the employee seeking leave may include assistance for basic medical, hygiene, nutritional, safety, transportation needs, the provision of physical or psychological care, or arranging for third party care for the family member.

1. 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 treatment(s):

2. Will the patient 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: _____

3. Will the patient require follow-up treatment, including any recovery time? ☐ 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.

4. During this time, will the patient need care which the employee's presence would be beneficial? ☐ Yes ☐ No

If yes, explain the care needed by the patient and why such care is **medically necessary.**

5. Is it **medically necessary** for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to care for the serious health condition of the family member? ☐ Yes ☐ No

If yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment(s):

_____hour(s) per day;_____days per week from_____through _____

6. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

If yes, 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 (i.e. 1 episode every 3 months lasting 1-2 days):

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

Duration: _____ hours _____ day(s) per event

Does the patient need care during these flare-ups? ☐ Yes ☐ No

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 above is true and accurate.

Printed Name of Health Care Provider

_____

Health Care Provider Signature

_____

Date

_____

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.