TULARE COUNTY

MEDICAL CERTIFICATION – EMPLOYEE'S FAMILY MEMBER'S SERIOUS HEALTH CONDITION

SECTION I: For Completion by the EMPLOYER

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits and employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in denial of your FMAL request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this for to your employer. 29 C.F.R. § 825.305.

Employee's Name:_____ Contact Phone While on Leave:_____

Employee's Department:_____ Title:_____

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you:_____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

SECTION III: For completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a conditions, 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 in; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for with the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical Specialty:_____

Telephone: (_____)_____ Fax: (_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of conditions: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? _____ No _____ Yes If so, dates of admission:_____

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

   Was medication, other than over-the-counter medication, prescribed? _____ No _____ Yes

   Will the patient need to have treatment visits at least twice per year due to the condition? _____ 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 nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? _____ No _____ Yes If so, expected delivery date: _____
3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? _____ No _____ Yes

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? _____ No _____ Yes

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? _____ 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:_____

   _____

   _____

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

   _____ No _____ Yes

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day: _____ days per week from_____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____ No _____ 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 (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

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

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

   _____

   _____

   ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

   _____

   _____

   _____

   _____

   _____

Signature of Health Care Provider: _____ Date: _____

Health Care Provider Address: _____

Health Care Provider Telephone: _____ FAX: _____

Please return this form to _____ (Name/Department)

Phone/FAX: _____

Serious Health Conditions

Define by the Family Medical Leave Act

_____ ***Hospital Care***

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

_____ ***Absence Plus Treatment***

(a) A period of incapacity of more than three consecutive, full calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2)Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment (e.g., prescription medication or therapy with specialized equipment but not over-the-counter medications or salves, bed rest, fluid intake, or exercise.) under the supervision of the health care provider. The in-person treatment visit must take place within seven days of the first day of incapacity. *****

NOTE: As the accepted practice of the County, the leave process is triggered by an absence of 40 hours or more. While the Absence Plus Treatment scenario is FMLA qualified and only three days in duration, the County practice of using 40+ hours as a benchmark to start the LOA process will continue to be followed. However; there may be cases in which an employee will qualify for FMLA under Absence Plus Treatment with out meeting the 40+ hours as stated in the personnel rule. In these cases, FMLA should be designated to comply with the Act.

_____ ***Pregnancy***

Any period of incapacity due to pregnancy, or for prenatal care.

_____***Chronic Conditions Requiring Treatments***

A chronic condition which:

(a) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

_____ ***Permanent/Long-term Conditions Requiring Supervision***

A period of incapacity which is permanent or long term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

_____ ***Multiple Treatments (Non-Chronic Conditions)***

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of healthcare services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three full consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).