TULARE COUNTY

MEDICAL CERTIFICATION – EMPLOYEE'S SERIOUS HEALTH CONDITION

SECTION I: For completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please have Section II completed by your employer before giving this form to your medical provider. The State and Federal leave laws permit an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for time protection leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of leave time protections under FMLA, CFRA and/or PDL.
Failure to provide a complete and sufficient medical certification may result in a denial of your leave request.

Your name: _____
First Middle Last

SECTION II: For completion by the EMPLOYER

Department name and contact: _____

Employee's job title: _____

Employee's regular work schedule: _____

Employee's essential job duties: _____

_____

Check if job description is attached: Yes ☐ No ☐

SECTION III: For completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested a leave related to their own serious medical condition. 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 protected leave 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: _____

_____

Telephone: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Estimated Return to Work Date: _____

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

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

   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, expected duration of treatment:

   _____

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

3. 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 able to perform the physical requirements and essential functions of his/her job due to the condition? ☐ No ☐ Yes

   If no, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts (other than a diagnosis and excluding genetic information*), if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED—SINGLE CONTINUOUS PERIOD

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:

   _____

PART C: AMOUNT OF LEAVE NEEDED—INTERMITTENT

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's 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 part-time 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 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 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 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. (ATTACH ADDITIONAL SHEETS IF NECESSARY)

_____

_____

_____ _____

Signature of Health Care Provider Date

Health Care Provider Address and Phone:_____

Please return this form to (Name/Department) _____
Phone/FAX _____

*"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Serious Health Conditions Defined 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 without 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).

***** CFRA covers all of the above, except pregnancy***
***** PDL covers pregnancy only***