# COUNTY OF ALAMEDA

# FAMILY AND MEDICAL LEAVES
# CERTIFICATION OF HEALTH CARE PROVIDER
**(Employee/Family Member)**

**Instructions for Employee:** Pursuant to the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), and/or Pregnancy Disability Leave (PDL) the purpose of this form is for health care providers to: 1) verify an injury or illness of an employee; or 2) verify an injury or illness of an employee's family member. Under FMLA/CFRA the definition of a "serious health condition" must be met. **This required certification must be completed by a health care provider and returned to your Human Resources Office/Disability Programs Division within 15 days.**

**Instructions for Health Care Provider: Our employee is requesting a leave pursuant to the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), and/or Pregnancy Disability Leave (PDL).** In your best estimate, based upon your medical knowledge, experience and examination, **please complete Sections I or II (as appropriate), and Section III.** Please limit your responses to the condition for which the employee is seeking leave. The Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other entities covered by CalGINA 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, please do not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by CalGINA, 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. Additionally, please do not disclose the patient's underlying diagnosis without consent. ***Please provide the employee's family member's health condition information on the reverse side (SECTION II).***

**Employee's Name:** _____ **Employee's ID#:** _____

## SECTION I- HEALTH PROVIDER'S VERIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION

☐ **Yes, I am the employee's health care provider and this is a serious health condition, as defined under the FMLA/CFRA/PDL, due to the following (please check):**

- **a.** ☐ **Hospital Care**
- **b.** ☐ **Absence Plus Treatment**
- **c.** ☐ **Pregnancy**
- **d.** ☐ **Chronic Conditions Requiring Treatment**
- **e.** ☐ **Permanent/Long-term Condition Requiring Health Care Provider Supervision**
- **f.** ☐ **Multiple Treatments (non-chronic conditions)**

1. ***Date*** employee's medical condition commenced**:** _____
2. ***Duration*** of employee's continuous period of incapacity: **From:** _____ **through:** _____
3. Is the employee ***unable to perform any one or more of his/her essential job functions*** based on your review of the employee's job description or the County's Description of Employee's Essential Job Functions (Form EF5)? ☐ **Yes** ☐ **No**
4. If the employee's medical condition is ***due to pregnancy,*** provide expected delivery date**:** _____
   - Is it medically advisable to ***transfer*** the employee to a less strenuous/hazardous position/or provide a ***reasonable accommodation***? ☐ **Yes** ☐ **No**
   - If yes, please specify accommodation or advisable position/job duties **From:** _____ **through:** _____

   _____
5. Is the employee able to ***perform temporary modified work*** of any kind? ☐ **Yes** ☐ **No; From:** _____ **through:** _____
   - ***Specify temporary work restriction(s):*** _____
6. Is it medically necessary for the employee to ***work on a temporary reduced work schedule?*** ☐ **Yes** ☐ **No**
   - **From:** _____ **through:** _____
   - ***Number of hours/days employee can work?*** _____ **hours per day *OR* :** _____ **days per week**
7. Is it medically necessary for the employee to ***attend follow-up treatments/appointments,*** including recovery time? ☐ **Yes** ☐ **No**
   ***Estimated frequency & duration of intermittent absences for treatments/appointments:***
   - **From:** _____ **through:** _____
   - **Frequency:** _____ **times per** _____ **week(s)** ***OR*** **:** _____ **times per** _____ **month(s)**
   - **Duration:** _____ **hours per treatment/appointment (including recovery time)**
8. Is it medically necessary for the employee to ***be absent from work on an intermittent basis and/or during episodic flare-ups?*** ☐ **Yes** ☐ **No;** ***Estimated frequency and duration of intermittent absences/flare-ups*****:**
   - **From:** _____ **through:** _____
   - **Frequency:** _____ **times per** _____ **week(s)** ***OR*** **:** _____ **times per** _____ **month(s)**
   - **Duration: hours per episode** ***OR*** **days per episode**

## SECTION II- FAMILY MEMBER'S HEALTH CONDITION INFORMATION

☐ **Yes, I am the employee's family member's health care provider and this is a serious health condition, as defined under the FMLA/CFRA/PDL, due to the following (please check):**

☐ **Hospital Care;** ☐ **Absence Plus Treatment;** ☐ **Pregnancy (Expected Due Date: _____);**
☐ **Chronic Conditions Requiring Treatment;** ☐ **Multiple Treatments (non-chronic conditions)**
☐ **Permanent/Long-term Condition Requiring Health Care Provider Supervision;**

1. **Name of family member:** _____ **Relationship to employee:** _____
   - If family member is the employee's son or daughter, please provide date of birth: _____
2. Will the patient be ***incapacitated for a single continuous period***, including any time for treatment and recovery? ☐ **Yes** ☐ **No**
3. ***Date*** condition commenced: _____ ***Duration*** of incapacity: **From:** _____ **through:** _____
   - During this time, does the patient ***require care/assistance with basic medical, hygienic, nutritional, safety, transportation or for the provision of physical or psychological care?*** ☐ **Yes** ☐ **No** If yes, please explain the type of care needed by the patient and why such care is medically necessary: _____
     _____
     _____
4. Was the patient ***admitted for an overnight hospital stay, hospice, or residential medical care facility*****?** ☐ **Yes** ☐ **No**
   - If so, **dates** of admission: _____
5. Are ***follow-up treatments/medical appointments needed*** (including any time medical necessary for recovery) at least twice per year, due to the patient's condition? ☐ **Yes** ☐ **No**
   - ***Please estimate the amount of time (frequency & duration) our employee is needed to care for patient/family member for treatments/appointments:***
   - **From:** _____ **through:** _____
   - **Frequency:** _____ **times per** _____ **week(s)** ***OR*** _____ **times per** _____ **month(s)** ***OR*** _____ **times per** _____ **year**
   - **Duration:** _____ **hours per treatment/appointments**
6. Will the patient ***require care on an intermittent basis*** due to the patient's condition/episodic flare-ups, including recovery time which will prevent the patient from participating in normal daily living activities for which the patient needs care? ☐ **Yes** ☐ **No**
   - ***Please estimate the amount of time (frequency & duration) our employee is needed to care for family member during flare-ups/incapacity:***
   - **From:** _____ **through:** _____
   - **Frequency:** _____ **times per** _____ **week(s)** ***OR*** _____ **times per** _____ **month(s)**
   - **Duration:** _____ **hours** ***OR*** _____ **days per episode**

## SECTION III- HEALTH CARE PROVIDER'S INFORMATION

**Health Care Provider's Additional Comments (if needed):**

_____
**Health Care Provider's Name (Please print)** **Complete Address (Please print)**

_____
**Type of Practice/Medical Specialty** **Telephone & Fax Numbers**

_____
**Signature of Health Care Provider** **Date**