



# Medical Certification Form

## INTERMITTENT LEAVE OF ABSENCE

**California Family Rights Act (CFRA) & Family Medical Leave Act (FMLA)**

**TO BE COMPLETED BY THE PATIENT'S HEALTH CARE PROVIDER:**

1. **EMPLOYEE'S NAME:** \_\_\_\_\_
2. **PATIENT'S NAME** (if other than employee): \_\_\_\_\_
3. **Date medical condition or need for treatment started:** \_\_\_\_\_
4. **Probable duration of medical condition or need for treatment:** \_\_\_\_\_

*(Note: The health care provider is not to disclose the underlying diagnosis without the consent of the patient)*

The attached Definition Sheet defines what is meant by a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA).

5. **Does the patient's condition qualify under any of the categories described?**  Yes  No

**IF THE PATIENT IS NOT AN EMPLOYEE OF SAN MATEO COUNTY, PLEASE SKIP TO QUESTION #7**

6. **Is the EMPLOYEE able to perform work of any kind?**
- Yes— EMPLOYEE can perform all duties.** However, employee is unable to work a full 40-hour work week and would benefit from a reduced work schedule as noted below:
- \_\_\_\_\_ hours per day  Mon  Tues  Wed  Thurs  Fri  Sat  Sun
- \_\_\_\_\_ hours per day  Mon  Tues  Wed  Thurs  Fri  Sat  Sun
- Yes— EMPLOYEE can perform all duties.** However, condition may flare intermittently and various leave and doctor's appointments will be required as noted below (approximately):
- \_\_\_\_\_ # of doctor visits per  Week  Month                      Length of Visits? \_\_\_\_\_
- If additional leave is required please indicate: \_\_\_\_\_ Hours per Day/ \_\_\_\_\_ Days per Week/ \_\_\_\_\_ Weeks per Month

7. **If the certification is for the care of the employee's family member, please answer the following:**

a. **What is the relationship between the patient and the San Mateo County employee?**

Spouse                       Domestic Partner

Parent                       Child

Young Adult Dependent Child

b. **The patient does or will require assistance for basic medical, hygiene, nutritional needs, safety or transportation.**  Yes  No

c. **Please describe, to the best of your ability, how often the San Mateo County employee will need to take leave from work to care for the covered family member:**

\_\_\_\_\_ # of doctor visits per  Week  Month                      Length of Visits? \_\_\_\_\_

If additional leave is required please indicate: \_\_\_\_\_ Hours per Day/ \_\_\_\_\_ Days per Week/ \_\_\_\_\_ Weeks per Month

**Additional Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Health Care Provider's Name:** \_\_\_\_\_ **Medical License Number:** \_\_\_\_\_

**Health Care Provider's Address:** \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF HEALTH CARE PROVIDER                      DATE

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE                      DATE

# Definition Sheet

A "serious health condition" under FMLA/CFRA means an illness, injury, impairment, or physical or mental condition that involves one of the following:

## 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 period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
- Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

## Pregnancy

- An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.
- A period of incapacity due to pregnancy, or for prenatal care.

## Chronic Conditions Requiring Treatment

- A chronic condition which:
- Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
- Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- 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 health care 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 consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).