COUNTY OF SONOMA, COUNTY AGENCIES AND SPECIAL DISTRICTS MEDICAL CERTIFICATION FOR FAMILY MEMBERS

Please use this form for a Leave of Absence requiring medical certification for an employee to care for a covered family member with a serious health condition. This form meets requirements of the California Family Rights Act (CFRA) and the federal Family Medical Leave Act (FMLA).

Instructions: The employee should complete Section I, then provide this form to the family member or his/her health care provider. Your assistance in providing a complete medical certification will help expedite approval of your leave request. Without complete and sufficient medical certification, your request may be delayed or even denied. Please return the completed form within 15 calendar days, unless it is not practicable to do so despite your diligent good faith efforts.

Emplo	yee's Name:				Department:
	,	First	Middle	Last	
(family	ined in the Son	noma County employer) fo	Medical Certion the purpose	fication form belo se of determini	(physician/practitioner), to provide the information ow. This certification will be provided to Sonoma Countying (employee) eligibility for
		(patio	ent), understar	nd that I have a ri	ght to receive a copy of this authorization.
	Sigr	nature of Patie	ent		/
Sectio	n II – HEALTH C	ARE PROVIDER	₹		
NOTE:	THE HEALTH CA	RE PROVIDER	IS NOT TO DISC	LOSE THE UNDERL	YING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT.
1.	Employee's N	lame:			
2.	Patient's Nar	ne:			
3.	Relationship	to employee:			
4.	Date medica	al condition or	need for treat	ment began:	
5.	Probable dur	ration of serio	us health cond	ition or need for t	reatment:
6.	Type of leave	e requested:	□ C	ontinuous	□ Intermittent
orovid taken	e and an estim intermittently o	nate of the tir or on a reduce	ne period durii ed work schedi	ng which this car	member, the employee shall state the care he or she will e will be provided, including a schedule if leave is to be on shall be provided separately and confidentially to the
7.	Medical Lea	ive Act (FML	A) and the C	California Family	us health condition" under both the federal Family and Rights Act (CFRA). Please check the box next to the

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of the following:

A. Hospital Care

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one

		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.					
В.	Ab	Absence Plus Treatment					
	A period of incapacity of more than three consecutive calendar days (including any subsequent treatment 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.					
C.	[NC	egnancy DTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA t not under CFRA.]					
		Any period of incapacity due to pregnancy, childbirth, pregnancy-related conditions, or for prenatal care.					
	Patient's expected delivery date:/						
D.	Chr	onic Conditions Requiring Treatment					
	Α	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).					
		May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).					
E. F	E. 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 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.					
F.	Mu	Itiple Treatments (Non-Chronic Conditions)					
		Any period of absence to receive multiple treatments (including any period of recovery therefrom) 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 (radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).					
Doe	es (c	or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?					
		□ Yes □ No					
Does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)							
		□ Yes □ No					

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8.

9.

	If yes, please provide an estima would be beneficial:	ite for the p	period of time care	is needed or	during which	n the employee's prese	ence
	_	/	/	_//			
10.	Please answer the following q schedule. Is it medically necess employee's normal work schedu	ary for the	employee to be of	f work on an	intermittent b		
		☐ Yes	□ No				
	If the answer to 10 is yes, please basis and/or the reduced work			for which the	e patient nee	eds care on an intermit	tent
	Hours Per Day		Days Per Week				
	Other:						_
							_
11.	Please provide any additional in	nformation,	if needed:				
12	Signature of health care provide		Type of Prophine		/	_/	
					Date		
	Email Address:						
	Telephone Number:						
	Street Address:				_		
FOR HU	JMAN RESOURCES/PAYROLL USE C	NLY					
Verified	d by Human Resources/Payroll:	Name			Date:	//_	

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DEPARTMENT WORKSHEET AND INSTRUCTIONS MEDICAL CERTIFICATION FOR FAMILY MEMBERS

The Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) allow the County of Sonoma to require an employee seeking FMLA/CFRA protections because of a need for leave due to a family member's serious health condition to submit a medical certification issued by the patient's health care provider.

You may not ask the employee to provide more information than allowed under the FMLA regulations, CFRA regulations, and/or the PDL regulations.

Employers must generally maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees created for FMLA/CFRA/PDL purposes as confidential medical records in separate files/records from the usual personnel files. Employers are required to comply with applicable law regarding the confidentiality of medical information requested.

Provide the Medical Certification for Family Member's form to the employee. The employee should then provide the form to the family member or his/her health care provider for completion and return within 15 days.

Employee Name	Department
Employee Job Title	
Employee Regular Work Schedule:	<u> </u>
Date Certification Provided to Employee://	
Date Certification Returned by Employee://	
Supervisor Name_	Supervisor Title:
Supervisor Phone:	_ sopervisor fille

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