County of Glenn

CERTIFICATION BY HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

(FAMILY AND MEDICAL LEAVE ACT/CALIFORNIA FAMILY RIGHTS ACT)

SECTION 1: For completion by the EMPLOYER	
Name of Agency/Department:	
Name of Employer Contact:	
Address of Employer:	
Employer Contact Phone:	Fax:
Employer Contact Email:	
SECTION 2: For completion by the EMPLOYEE	
INSTRUCTIONS to the EMPLOYEE: Please complete Section 2 before giving this form to your family member or his/her medical provider. If requested by your employer, your response is required to obtain or retain the benefit of FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA/CFRA request. Your employer must give you at least 15 calendar days to return this form.	
Name of Employee:	
Name of family member for whom you will provide care:	
Relationship of family member/patient to you:	
Describe care you will provide to your family member and estimate leave needed to provide care:	
Employee Signature: ______________________________	Date: ______________
SECTION 3: For completion by the HEALTH CARE PROVIDER	
INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed in Section 2 has requested leave under FMLA/CFRA to care for your patient. Please answer all questions relative to the patient listed in Section 2 as fully and completely as possible. There are questions that require answers about the frequency or duration of a condition or treatment. 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 FMLA/CFRA coverage. Please be sure to sign the second page of the form.	
Part A: MEDICAL FACTS	
1. Does the patient have a serious health condition? ☐ Yes (go to #2) ☐ No (provide signature and return to employer listed in Section 1) * "**Serious Health Condition**" means an illness, injury, (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, or spouse of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse.	
2. Approximate begin date of condition:	
3. Probable duration of condition:	
4. Date(s) you treated the patient for condition:	
5. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes	

6. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (e.g. symptoms, diagnosis, continuing treatment, use of specialized equipment):

Part B: AMOUNT OF CARE NEEDED

1. Will the patient be incapacitated for a single continuous period of time? ☐ No ☐ Yes

   If yes, estimate begin and end dates for the period of incapacity:

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

   If yes, please explain the care needed by the patient:

2. Will the patient require follow-up treatments, including time for recovery? ☐ No ☐ Yes

   If yes, estimate treatment schedule, including dates of follow-up appointments and time required for each appointment, including any recovery period:

   If yes, please explain the care needed by the patient:

3. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

   Based on the patient's medical history and condition, please estimate frequency and possible duration of flare-ups within the next six months:

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

   If yes, please explain the care needed by the patient:

Name of Health Care Provider:

Health Care Provider Business Address:

Telephone Number:	Fax:

Type of Practice/Medical Specialty:

Signature of Health Care Provider: ________________________________	**Date:** ________________

California Genetic Information Nondiscrimination Act of 2011

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic Information,” as defined by CalGINA, includes information about the individual’s or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. “Genetic Information” does not include information about an individual’s sex or age.