COUNTY OF GLENN

MEDICAL CERTIFICATION FOR COVERED SERVICEMEMBER MILITARY FMLA LEAVE FORM

Please use this form for a Leave of Absence requiring medical certification for an employee to care for a family member who is a covered service 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.

1. FAMILY MEMBER

Employee's Name: _____

Department:_____

Supervisor:_____

I, _____ (patient), hereby authorize _____ (physician/practitioner), to provide the information contained in the Glenn County Medical Certification form below. This certification will be provided to Glenn County (family member's employer) for the purpose of determining _____ (employee) eligibility for family/medical leave for a covered service member, as provided by state and federal law. This authorization is valid for _____(amount of time) from the date of my signature below.

I,_____ (patient), understand that I have a right to receive a copy of this authorization.

_____ _____/_____/_____
Signature of Patient Date

2. HEALTH CARE PROVIDER

(United States Department of Defense (DOD) Health Care Provider or other Health Care Provider who is 1) a United States Department of Veterans Affairs (VA) provider, 2) a DOD TRICARE network authorized private health care provider.
NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS.

1. Employee's Name: _____

2. Covered Service Member's Name:
_____

3. Relationship to employee:
_____

4. Period of covered service member's active duty: _____

5. Date medical condition or need for treatment began: _____/_____/_____

6. Probable duration of serious health condition or need for treatment:

_____

7. Type of leave requested: ☐Continuous ☐ Intermittent

When family care leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule. This information shall be provided separately and confidentially to the health care provider for use in completing the below information.

8. The definitions below describe 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). **Please check the box next to the appropriate category for the patient's condition.**
A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

A. 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.

B. 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

☐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. Pregnancy

☐ Any period of incapacity due to pregnancy, childbirth, pregnancy-related conditions, or for prenatal care.
Patient's expected delivery date: _____/_____/_____

D. 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).

☐ May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

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 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.

F. Multiple 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).

9. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

☐ Yes ☐ No

10. 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

If yes, please provide an estimate for the period of time care is needed or during which the employee's presence would be beneficial: _____/_____/_____ - _____/_____/_____

11. Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule.

Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to provide care to the patient?

☐ Yes ☐No

If the answer to question 11 is yes, please indicate the estimated hours for which the patient needs care on an intermittent basis: Please estimate the reduced work schedule the employee needs:

Hours per day _____ Days per week _____

12. Please provide any additional information, if needed:
_____
_____
_____
_____
_____

13. _____ _____ _____/_____/_____
Signature of Health Care Provider Type of Practice Date

Email Address:_____

Street Address :_____
_____