COUNTY OF ALAMEDA

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

Pursuant to the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA), and/or Pregnancy Disability Act (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 returned to your Human Resources Office within 15 days.**

For Health Care Provider: In your best estimate, based upon your medical knowledge, experience and examination, **please complete Sections I-IV** (as appropriate), sign and date this form. Please limit your responses to the condition for which the employee is seeking leave. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA 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, do not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, 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.

Employee's Name: ___________________________________ **Employee's ID#:** ______________________________

Family Member's Name: _______________________________ **Relationship to Employee:** _____________________

SECTIONS I-IV TO BE COMPLETED BY HEALTH CARE PROVIDER

SECTION I- VERIFICATION OF HEALTH CONDITION

☐ Yes, I am the health care provider and this is a serious health condition, as defined under the FMLA/CFRA, due to the following:

1. ☐ Inpatient hospital care
2. ☐ Absence (incapacitation) of more than three days and continuing treatment
3. ☐ Condition related to pregnancy/childbirth/prenatal care
4. ☐ Chronic serious health condition requiring periodic visits for treatment
5. ☐ Permanent or long-term condition requiring continued supervision of a health care provider
6. ☐ Absences to receive multiple treatments

SECTION II- EMPLOYEE'S HEALTH CONDITION INFORMATION

1. Date condition commenced: ______________
2. Duration of incapacity: From: ___________ through :___________
3. Is the employee unable to perform any one or more of the essential job functions? ☐ Yes ☐ No
4. If the medical condition is due to pregnancy, childbirth or related medical conditions, provide expected delivery date: ___________
   - Due to pregnancy or related medical condition, is it medically advisable to transfer the employee to a less strenuous or hazardous position or job duties? ☐ Yes ☐ No
5. Is the employee able to perform temporary modified work of any kind? ☐ Yes ☐ No From: __________ through: __________
   - Temporary work restriction(s): ____
6. Is it medically necessary for the employee to work on a temporary reduced work schedule? ☐ Yes ☐ No
   - If yes, how many hours can the employee work? ___________ per day, __________ per week;
   - From: ______________ through: ________________
7. Is it medically necessary for the employee to attend follow-up treatments/appointments, including recovery time? ☐ Yes ☐ No
   - Estimated frequency of ***intermittent absence for treatments/appointments:***
     - From: ______________ through: ________________
     - Frequency: ______times per ______week(s) _______month(s)
     - Duration:______hours per treatment/appointment
8. Is it medically necessary for the employee to be off work on an ***intermittent basis*** and/or during episodic flare-ups? ☐ Yes ☐ No
   - Estimated frequency of ***intermittent absences/flare-ups:***
     - From: ______________ through: ________________
     - Frequency: ______times per ______week(s) _______month(s)
     - Duration:______hours or ______day(s) per episode

SECTION III- FAMILY MEMBER'S HEALTH CONDITION INFORMATION

1. Duration of incapacity: From: ___________ through:____________ Date condition commenced: ___________

2. During this time, does the family member require assistance with basic medical, hygienic, nutritional, safety, transportation or for the provision of physical or psychological care? ☐ Yes ☐ No If yes, please explain type of care needed by the patient and why such care is medically necessary:

3. Will the family member require follow-up treatments (e.g., physical therapy) including any time medically necessary for recovery?
   ☐ Yes ☐ No

   - If yes, estimate treatment schedule, including dates of any scheduled appointments and time required for appointments:

4. Will the family member require follow-up treatments (e.g., physical therapy), including recovery time? ☐ Yes ☐ No

   - Estimated frequency of ***treatments*/appointments:**
     - From: ______________ through: ________________
     - Frequency: _____times per _____week(s) _____month(s)
     - Duration:______hours per treatment/appointment

5. Will the patient's condition cause episodic flare-ups periodically preventing the patient from participating in normal daily living activities for which the patient needs care? ☐ Yes ☐ No

   - Estimated frequency of family member's ***flare-ups/incapacity*:**
     - From: ______________ through: ________________
     - Frequency: _____times per _____week(s) _____month(s)
     - Duration:_____hours or _____day(s) per episode

6. Is the family member's medical condition due to pregnancy? ☐ Yes ☐ No If yes, expected delivery date: ____________________

SECTION IV- HEALTH CARE PROVIDER'S INFORMATION

Health Care Provider's – Additional Comments (if any):

____

Provider's Name **Address**

____

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

____

Signature of Health Care Provider **Date**