

**FAMILY CARE AND MEDICAL LEAVE
CERTIFICATION OF HEALTH CARE PROVIDER**

COUNTY OF IMPERIAL

1. Employee's Name	2. Patient's Name (if different from employee)
3. The back of this form describes what is meant by a "serious health condition" under Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. (1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____, or None of the above _____	
4. Describe medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:	
5. Date condition commenced:	6. Probable duration of condition:
7. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the Employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week):	
IF MEDICAL LEAVE IS FOR THE EMPLOYEE'S OWN CONDITION PLEASE COMPLETE QUESTIONS 8 – 9. IF NOT, SKIP TO QUESTION 10	
8. Is inpatient hospitalization of the employee required? _____ Yes _____ No	9. Is employee able to perform work of any kind? _____ Yes _____ No (if No, skip question 9)
10. Is employee able to perform the functions of the employee's position? (Answer after reviewing statement from employer of essential function of employee's position, or if none provided, after discussing with employee) _____ Yes _____ No	
IF MEDICAL LEAVE IS TO CARE FOR THE EMPLOYEE'S SEROUSLY ILL FAMILY MEMBER, COMPLETE QUESTIONS 10-13. IF NOT, PROCEED TO QUESTION 14.	
11. Is inpatient hospitalization of the family member (Patient) required? _____ Yes _____ No	12. Does (or will) the patient require assistance for basic medical, hygiene, nutritional need, safety or transportation? _____ Yes _____ No
13. Is the employee's presence needed or warranted for the Patient? _____ Yes _____ No	14. Estimate the period of time care by employee is needed or warranted:

15. Name of Physician/Practitioner		
16. Address of Physician/Practitioner:		
17. Phone #:		
18. Signature of Physician/Practitioner:		Date:

THIS SECTION IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER:	
State the care you will provide and an estimate of the period during which care will be provided including a schedule if leave is to be taken intermittently or on a reduced leave schedule:	
Employee Signature:	Date:

OFFICIAL USE ONLY:	Received on:

A "Serious Health Condition" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care
Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity¹ or subsequent treatment in connection with or consequent to such inpatient care.
2. Absence Plus Treatment
 - a. A period of incapacity¹ of **more than three consecutive calendar days** (including any subsequent treatment of period of incapacity¹ relating to the same condition), that also involves:
 - i. **Treatment² 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
 - ii. **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment³** under the supervision of the health care provider.
3. Pregnancy
Any period of incapacity due to **pregnancy**, or for **prenatal care**.
4. Chronic Conditions Requiring Treatments
 - a. A **chronic condition** which:
 - i. 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;
 - ii. Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
 - iii. May cause **episodic** rather than a continuing period of incapacity¹ (e.g., asthma, diabetes, epilepsy, etc.).
5. Permanent/Long-Term Conditions Requiring Supervision
A period of **Incapacity¹** which is **permanent of 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.
6. Multiple Treatment (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 incapacity¹ 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), and kidney disease (dialysis).

¹ "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

² **Treatment** includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

³ A regimen of **continuing treatment** includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.
