HUMAN RESOURCE DEPARTMENT:
251 E HONOLULU., P.O. Box 369
Lindsay, CA 93247
Tel.559.562.7102 XT 8033
FAX:559-562-1520

SAMPLE MEDICAL CERTIFICATION – EMPLOYEE'S SERIOUS HEALTH CONDITION

SECTION I: For completion by the EMPLOYER

Employer's name and contact person:_____

Employee's job title:

_____

Employee's regular work schedule:_____

Employee's essential job functions:

_____

_____

Check if job description is attached: ____

SECTION II: For completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA and/or CFRA permit an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA and/or CFRA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA and/or CFRA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA and/or CFRA request. Your employer must give you at least 15 calendar days to return this form.

Your name: _____
First Middle Last

SECTION III: For completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA and/or CFRA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. 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

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"indeterminate" may not be sufficient to determine FMLA and/or CFRA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice/Medical specialty: _____

Telephone: (_____)_____

PART A: MEDICAL FACTS

[NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS, MEDICAL HISTORY OR TREATMENT PLAN]

1. Approximate date condition commenced:
_____ _

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

❑ No ❑ Yes. If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition?

❑ No ❑ Yes

Was medication, other than over-the-counter medication, prescribed? ❑ No ❑ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (*e.g.,* physical therapist)? ❑ No ❑ Yes. If so, state the nature of such treatments and expected duration of treatment:

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2. Is the medical condition pregnancy? ❑ No ❑ Yes. If so, expected delivery date:

3. Is the employee able to perform work of any kind? ❑ No ❑ Yes.
(If "No", skip next question.)

4. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition:
   ❑ No ❑ Yes

   If so, identify the job functions the employee is unable to perform:

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ❑ No ❑ Yes

   If so, estimate the beginning and ending dates for the period of incapacity:

6. Is it medically necessary for the employee to be off work on an intermittent basis or to work a reduced number of hours of work in order to deal with the employee's serious health condition? ❑ No ❑ Yes

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ❑ No ❑ Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   Estimate the part-time or reduced work schedule the employee needs, if any:

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_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ❑ No ❑ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups? ❑ No ❑ Yes. If so, explain:

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (*e.g.*, 1 episode every 3 months last 1-2 days):

Frequency: _____ times per _____ week(s) _____ month (s)

Duration: _____hours or _____day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SIGNATURE OF HEALTH CARE PROVIDER DATE