Stockton Unified School District

MEDICAL CERTIFICATION FOR EMPLOYEES OWN MEDICAL CONDITION

Please use this form for a Leave of Absence requiring medical certification. 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 health care provider. 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.

Section I- EMPLOYEE

Employee's Name: _____

Employee ID#: _____

Department: _____

First Middle Last

I, _____, hereby authorize _____ (physician/practitioner), to provide the information contained in the Stockton Unified School District (SUSD) Medical Certification form below for the purpose of determining my eligibility for family/medical leave, as provided by state and federal law.

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

_____ _____/_____/_____

Signature of Employee Date

Section II – HEALTH CARE PROVIDER

NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT.

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

2. Date employee is expected to be able to return to work: _____/_____/_____

3. Type of leave requested: A. Continuous B. Intermittent (circle one)

4. 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 circle the 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-F):

A. Hospital Care Yes_____ No_____

- 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 Yes_____ No_____

- 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 Disability Yes ____ No _____ NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.]

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 (circle if applicable) Yes_____ No _____

A chronic condition:

- 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 Yes____ No_____

A period of incapacity, which is permanent or long-term due to a condition for which treatment may not be effective. The employee 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) Yes_____ No_____

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 healthcare 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).

5. If any "serious medical condition" (A-F) is checked under #4 above, please answer the following after reviewing the statement from the employer of essential functions of employee's position, or if none provided, based upon the employee's own description of his/her essential functions:

- **Is employee able to perform work of any kind? (If "No", skip next question Yes____ No____**

- **Is employee unable to perform any one or more of the essential functions of employee's position due to the serious health condition? Yes_____ No_____**

If yes, please specify the employee's work restrictions that preclude him/her from performing essential job functions:

_____
_____
_____

_____

_____

6. 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 due to the serious health condition of the employee?

Yes _____ No _____

If the answer to 6 is yes, please estimate the hours for which the employee needs intermittent leave and/or the reduced work schedule needed:

Hours Per Day _____ Days Per Week _____

Other information needed for intermittent leave:

_____

_____

7. Please provide any additional information, if needed:

_____

_____

_____

_____

_____ _____/_____/_____

Signature of Physician Date

Type of Practice: _____

Email Address: _____

Telephone Number: _____

Street Address: _____

_____ _____/_____/_____

Signature of Employee Date

Updated 4/2/24 LV