Stockton Unified School District

Medical Certification – FMLA/CFRA

To be completed by the patient's health care provider:

1. Employee's Name: _____

2. Patient's Name (if other than employee):
_____

3. Date medical condition or need for treatment commenced:
_____

(Note: The health care provider is not to disclose the underlying diagnosis without the consent of the patient.)

4. Probable duration of medical condition or need for treatment: _____

5. The attached sheet (page 4) describes 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). Does the patient's condition qualify under any of the categories described?

____ Yes ____ No

FOR CONDITION OF EMPLOYEE:

6. If the certification is for the serious condition of the employee, please answer the following:

a. Is the employee able to perform work of any kind?

____ Yes ____ No

b. Is the employee able to perform the essential functions of the Employee's position? Answer after reviewing the employer's job description that includes the essential functions of the Employee's position, or if none provided, after discussing with the employee.

____ Yes ____ No

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

a. 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 deal with the serious health condition of the employee or family member?

____Yes ____ No

b. If the answer to "a" is yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider.

Estimate: _____

FOR CONDITION OF EMPLOYEE'S FAMILY MEMBER:

8. If the certification is for the care of the Employee's family member, please answer the following:

a. The patient does or will require assistance for basic medical, hygiene, nutritional needs, safety or transportation.

____Yes ____ No

b. After review of the Employee's signed statement (see item 10, attached) 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

9. Estimate the period of time care will be needed or during which the Employee's presence would be beneficial:

Estimate:_____

_____ _____

Signature of Health Care Provider Date

Health Care Provider Stamp

_____ _____

Signature of Employee Date

To be completed by the employee needing family leave to care for a seriously ill family member.

Please provide to the healthcare provider under separate cover.

This information is not to be provided by the medical provider.

10. When family care leave is needed to care for a seriously ill family member, the employee must state the care he/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:

_____
_____
_____
_____
_____

_____ _____

Signature of Employee Date

Definitions
(Attach to Medical Certification)

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 incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   a. 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 assistant under direct supervision of a health care provided, 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.

3. Pregnancy
   (Note: An Employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.)

   A period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatment

   A chronic condition which:

   a. 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;

   b. Continues over an extended period of time (including recurring episodes of a single underlying condition);

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

5. Permanent/Long-Term Conditions Requiring Supervision

   A period of incapacity that is permanent or 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 Treatments (Non-Chronic Conditions)

   Any period of absence to receive multiple treatments (including any period of recovery there from) 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 (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).