COUNTY OF RIVERSIDE
Human Resources Department

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

♦ **Family and Medical Leave Act (FMLA)** ♦ **California Family Rights Act (CFRA)**
♦ **California Pregnancy Disability Act (PDL)**

SECTION I: For Completion by the EMPLOYER

Department:	Department Contact:	Phone Number: ( )	Fax Number: ( )

Last Day Worked:	☐ Check if Job Description is Attached

Employee's Essential Job Functions:

SECTION II: For Completion by the EMPLOYEE

Instructions to the Employee: Section I must be completed by your department representative and you must complete Section II before giving this form to your medical provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support a request for medical leave due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA, CFRA, or PDL protections. Failure to provide a complete and sufficient medical certification may result in a denial of your leave request. **You have 15 calendar days to return this form.**

Employee Name (Last, First, Middle):	Daytime Contact Phone Number:
Official County Job Title:	Employee ID Number:

Regular Work Schedule: ☐ Days ☐ Nights ☐ Full-Time ☐ Part-Time ☐ 9/80 ☐ 4/10 ☐ 5/40 ☐ Other: _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under FMLA/CFRA/PDL. 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 "indeterminate" may not be sufficient to determine FMLA, CFRA, and/or PDL coverage. Limit your responses to the condition for which the employee is seeking leave. **Please be sure to sign and date the form on the last page.**

The **Genetic Information Nondiscrimination Act of 2008 (GINA)** prohibits employers and other entities governed 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, we are asking that you 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 individual's family member sought or received genetic services, and genetic information of a fetus to be 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.

Provider Name (You may attach a business card in lieu of completing this section):	License Number:

Address (Street Address, Suite Number, City, State, Zip Code):

Type of Practice/Medical Specialty:

Telephone: ( )	Fax: ( )

Employee Name (Last, First, Middle):	Employee ID Number:

PART A. MEDICAL FACTS

Is the medical condition pregnancy-related?

☐ No ☐ Yes

If yes, proceed to page 4 and complete the Pregnancy Disability Certification Form.

Approximate Date Condition Commenced:	Probable Duration of Condition:

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

☐ No ☐ Yes If yes, dates of admission: _____

Dates you treated patient for condition: _____

Will the patient need to have treatment visits at least twice per year due to a chronic 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 yes, state the frequency and expected duration of such treatments and duration of treatment(s): _____

Is the employee unable to perform any of his/her job functions due to his/her medical condition? (See Essential Job Functions and/or Attached Job Description.)

☐ No ☐ Yes

If yes, identify the job functions the employee is unable to perform and work restrictions:

_____

_____

Can the employee perform modified duty?

☐ No ☐ Yes

PART B. AMOUNT OF LEAVE NEEDED

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 yes, estimate the beginning and ending dates for the period of incapacity: _____

Will the employee need to attend follow-up treatment appointments because of the medical condition?

☐ No ☐ Yes

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

_____

_____

Will the employee need to work part-time or on a reduced schedule because of the employee's medical condition?

☐ No ☐ Yes

If yes, are the reduced hours of work **medically necessary**?

☐ No ☐ Yes

If yes, estimate the part-time or reduced work schedule the employee needs:

_____ Hours per day; _____ Days per week; From _____ Through _____

Will the condition cause episodic flare-ups periodically, preventing the employee from performing his/her job functions?

☐ No ☐ Yes

If yes, 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 lasting 1-2 days):

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

Duration: _____ hours _____ day(s) per event

Employee Name (Last, First, Middle):	Employee ID Number:

ADDITIONAL INFORMATION:

Note: Please attach a separate sheet of paper if additional space is needed.

Signature of Health Care Provider

Date

ONLY COMPLETE THIS FORM FOR PREGNANCY DISABILITY

PREGNANCY DISABILITY CERTIFICATION FORM FOR
COMPLETION BY THE HEALTH CARE PROVIDER

Patient Name: _____ Employee I.D. Number (HR or employee completes) _____

Expected Delivery Date: _____

Please certify that, because of this patient's pregnancy, childbirth, or a related medical condition (including, but not limited to, recovery from pregnancy, childbirth, loss or end of pregnancy, or postpartum depression), this patient needs (check all boxes that apply):

☐ Time off for medical appointments (Please specify frequency and duration.)

_____

_____

☐ Leave of absence (Due to the patient's pregnancy, childbirth or a related medical condition, she cannot perform one or more of the essential functions of her job or cannot perform any of these functions without undue risk to herself, to her pregnancy's successful completion, or to other persons.)

Beginning (Estimate):_____

Ending (Estimate):_____

If intermittent leave of absence is medically advisable, please specify the frequency and duration of such:

_____

_____

☐ Reduced work schedule (Please specify the medically advisable reduced work schedule.)

_____

_____

Beginning (Estimate):_____

Ending (Estimate):_____

☐ Transfer to a less strenuous or hazardous position or to be assigned to less strenuous or hazardous duties (Please specify what would be a medically advisable position/duties.)

_____

_____

Beginning (Estimate):_____

Ending (Estimate):_____

☐ Reasonable accommodation (Please specify the medically advisable needed accommodation.) These could include, but are not limited to, modifying lifting requirements, providing more frequent breaks, or providing a stool or chair.

_____

_____

_____ _____

Signature of Health Care Provider Date