COUNTY OF RIVERSIDE
Human Resources Department

CERTIFICATION OF HEALTHCARE PROVIDER FOR FAMILY MEMBER'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 EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member or his/her health care provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support a request for leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA/CFRA 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): Contact Phone: ( )

Department: Employee ID Number:

Last Day Worked:

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

Name of the family member for whom you will provide care (Last, First, Middle):

Relationship of the family member to you:
☐ child/child of domestic partner ☐ spouse
☐ parent ☐ domestic partner

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

I certify that the information I have provided above is true and correct.

_____ _____
Employee Signature Date

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under FMLA/CFRA to care for your patient. Answer all applicable parts fully and completely. 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 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

Approximate Date Condition Commenced: Probable Duration of Condition:

Was the patient admitted for an overnight stay (or an 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 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:

_____

_____

Was medication, other than over-the-counter medication, prescribed?

☐ No ☐ Yes

PART B. AMOUNT OF CARE NEEDED (When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygiene, nutritional, safety, or transportation needs, or the provision of physical or psychological care.)

Will the patient 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: _____

During this time, will the patient need care?

☐ No ☐ Yes If yes, explain the care needed by the patient and why such care is **medically necessary**:

_____

_____

_____

_____

_____

Please answer the following questions only if the employee is requesting 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 in order to care for the serious health condition of the family member?

☐ No ☐ Yes

If yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment(s).

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

ADDITIONAL INFORMATION:

_____

_____

_____

_____

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

_____ _____

Signature of Health Care Provider Date

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