COUNTY OF RIVERSIDE
Human Resources Department

Certification of Health Care Provider for Family Member's Serious Health Condition

•Family and Medical Leave Act (FMLA) •California Family Rights Act (CFRA)

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) ____________________ Daytime Contact Phone ____________________

Department ____________ Employee ID Number ____________ Last Day Worked ____________

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

Name of the family member for whom you will provide care (Last, First, Middle) ____________________ Family member's date of birth ____________

Relationship of the family member to you:
☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Grandparent ☐ Parent-in-law
☐ Child/child of domestic partner ☐ Sibling ☐ Grandchild ☐ Other Designated Person : ____________

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

I certify that the information I have provided 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	Employee ID Number

PART A: PATIENT'S MEDICAL FACTS

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: ______________________

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

☐ No ☐ Yes If yes, please list the anticipated dates patient will receive treatment:

____

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

☐ No ☐ Yes ______________________

Will the patient need multiple treatment visits due to a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical treatment (e.g., physical therapy, chemotherapy, dialysis, etc.)?

☐ No ☐ Yes If yes, please state the anticipated frequency, duration and dates of such treatments and duration of treatment(s):

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

From: ____________ Through: ____________

PART B: AMOUNT OF CARE NEEDED FROM EMPLOYEE

(When answering these questions, keep in mind that your patient's need for care by the employee seeking to leave may include assistance such as basic medical, hygiene, nutritional, safety, or transportation needs, or the provision of physical or psychological care.)

During this time, will the patient need continuous care from the employee?

☐ No ☐ Yes If yes, please estimate the beginning and ending dates for the continuous period of care:

From: ____________ Through: ____________

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 frequency/duration of intermittent leave the employee will need to care for the patient:

__________ Hours per day; __________ Days per week; From: ____________ Through: ____________

ADDITIONAL INFORMATION:

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

______________________ ____________

Signature of Health Care Provider Date