



Physician Certification Form – Serious Health Condition (Employee or Family Member)

Pursuant to the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA), and/or Pregnancy Disability Act (PDL) the purpose of this form is for health care providers to verify an injury or illness of an employee or an employee's family member. Under FMLA/CFRA the definition of a "serious health condition" must be met.

Section I: Employee Contact Information

Employee Name _____

(If for employee, complete sections II & III)

Family Member Name _____ **Relationship** _____

(If for family member complete sections II & IV)

Section II – Verification of Serious Health Condition

Health Care Provider: The employee named in Section I has requested leave under FMLA, CFRA or PDL. Please limit your responses to the condition for which the employee is seeking leave. Please complete this form based upon your medical knowledge, experience and examination of the patient. Be as specific as you can without compromising HIPPA laws. Do not provide any genetic information as defined by the GINA Act. Answer all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Please be sure to sign the form on last page.

Yes, I am the health care provider and this is a serious health condition, as defined under the FMLA/CFRA, due to at least one of the following:

- Inpatient hospital care
- Condition related to pregnancy/childbirth/prenatal care
- Absence (incapacitation) of more than three days and continuing treatment
- Chronic condition requiring periodic visits or continued supervision of a health care practitioner

Date condition commenced: _____ **Anticipated end date:** _____

Section III – Employee's Health Condition Information

Job Title: _____ **Work Schedule** _____

Essential Job Functions: See Physical Demands, Working Conditions and Special requirements in the attached Job Class Specification.

1. **Maternity leave** - If the medical condition is due to pregnancy, childbirth or related medical conditions, provide expected delivery date: _____

Other instructions or restraints with regard to job duties: _____

2. **Consecutive leave** - If the employee is *unable* to perform work of any kind at this time (Answer after reviewing the employer's job description, or if none provided, after discussing with the employee.), indicate the duration of incapacity.
From _____ through: _____

3. Reduced work schedule - If it is medically necessary for the employee to work on a temporary reduced work schedule or have a regimen of periodic treatments, indicate the number of hours the employee can work _____ per day, _____ per week;

From: _____ through: _____

Frequency of appointments

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

From _____ through: _____

4. Temporary modified work – If the employee can work with temporary modified restrictions indicate what they are: _____

From: _____ through: _____

Section IV – Family Member Health Condition Information

1. During this time, does the family member require assistance with basic medical, hygienic, nutritional, safety, transportation or for the provision of physical or psychological care? If yes, please explain:

Type of care needed by the patient and why such care is medically necessary

Frequency of appointments

From _____ through: _____

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

2. If the family member's condition is due to pregnancy, what is the expected delivery date: _____

Section IV – Health Care Provider Information

Health Care Provider's – Additional Comments (if any):

Provider's Name

Address

Provider Signature

This required certification must be returned to Human Resources within 15 days.

Email: HRLeaves@marincounty.org

Phone: (415) 473 – 6598

Fax: (415) 473 - 5960

County of Marin, Human Resources Department
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San Rafael, CA 94903-4177