COUNTY OF SONOMA, COUNTY AGENCIES AND SPECIAL DISTRICTS MEDICAL CERTIFICATION FOR EMPLOYEES

Please use this form for a Leave of Absence requiring medical certification. This form meets requirements of the California Family Rights Act (CFRA) and the federal Family Medical Leave Act (FMLA).

Instructions: The employee should complete Section I, then provide this form to the health care provider. Your assistance in providing a complete medical certification will help expedite approval of your leave request. Without complete and sufficient medical certification, your request may be delayed or even denied. Please return the completed form within 15 calendar days, unless it is not practicable to do so despite your diligent good faith efforts.

Section	n I – I	EMPLC	DYEE							
Employ	yee's	Nam	e: First	Middle	Las	st	Dep	oartment:		
						•				
contai	ned	in the	Sonoma Cou	nty Medical C	Certification for	orm belo	ow. This cer	ician/practitione	provided to So	noma County
(emplo	oyer)	for th	e purpose of d	etermining my	eligibility for	family/r	medical leav	ve, as provided b	y state and fed	deral law.
l,			(e	mployee), un	derstand tha	t I have	a right to red	ceive a copy of t	his authorizatio	n.
			6					//_ Date		
			Signature of E	mpioyee				Date		
Sectio	n II –	HEALT	TH CARE PROVI	DER						
NOTE:	THE H	IEALTH	H CARE PROVID	ER IS NOT TO I	DISCLOSE THE	UNDERL	YING DIAGN	NOSIS WITHOUT TH	IE CONSENT OF	THE PATIENT.
1.	Da	te me	edical condition	n or need for t	reatment be	gan:	/	/		
2.						•		/		
3.			eave requeste		Continuou		☐ Intermitt			
4.	Me	dical		MLA) and th	e California			ondition" under t (CFRA). Please		
			s health condi llowing:	tion" means a	n illness, injur	ry, impai	rment, or pl	hysical or mental	condition that	involves one
	Α.	Hosp	oital Care							
								, or residential me ection with or co		
	В.	Abse	ence Plus Treat	ment						
	A period of incapacity of more than three consecutive cale period of incapacity relating to the same condition), that a								any subsequen	treatment or
				a health care	e provider, o	or by a p	provider of h	a nurse or phys nealth care servi		

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		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.				
C.	Pregnancy [NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.]					
		Any period of incapacity due to pregnancy, childbirth, pregnancy-related conditions, or for prenatal care.				
	Pat	ient's expected delivery date:/				
D.	Chro	onic Conditions Requiring Treatment				
	A	chronic condition which:				
		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.				
		Continues over an extended period of time (including recurring episodes of a single underlying condition).				
		May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).				
E.	Perm	nanent/Long-term Conditions Requiring Supervision				
		A period of incapacity, which is permanent or long-term due to a condition for which treatment may not be effective. The employee 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.				
F.	Μu	Itiple Treatments (Non-Chronic Conditions)				
		Any period of absence to receive multiple treatments (including any period of recovery therefrom) 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 (radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).				
em	any box is checked under #4 above, please answer the following after reviewing the statement from the imployer of essential functions of employee's position, or if none provided, based upon the employee's own description of his/her essential functions:					
ls e	empl	oyee able to perform work of any kind? (If "No", skip next question.)				
		byee unable to perform any one or more of the essential functions of employee's position due to the serious condition?				
	yes, nction	please specify the employee's work restrictions that preclude him/her from performing essential job ns:				

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6.	Please answer the following question only if the employee is asking for 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 due to the serious health condition of the employee?								
		□ Yes	□ No						
	If the answer to 6 is yes, please estimate the hours for which the employee needs intermittent leave and/or the reduced work schedule needed:								
	Hours Per Day	Days Per Wee	ek						
	Other:								
7.	Please provide any additional information	on, if needed: _							
8.	Signature of health care provider Email Address:		_	//					
	Telephone Number:			_					
9.	Signature of Employee:			Date:					
FOR H	UMAN RESOURCES/PAYROLL USE ONLY								
Verifie	ed by Human Resources/Payroll: Name			Date:/					

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DEPARTMENT WORKSHEET AND INSTRUCTIONS MEDICAL CERTIFICATION FOR EMPLOYEES

The Family and Medical Leave Act (FMLA), the California Family Rights Act (CFRA), and the Pregnancy Disability Leave provisions of the Fair Employment and Housing Act ("PDL"), as applicable, allow the County of Sonoma to require an employee seeking FMLA, CFRA, and/or PDL protections because of a need for leave due to the employee's serious health condition to submit a medical certification issued by the employee's health care provider.

You may not ask the employee to provide more information than allowed under the FMLA regulations, CFRA regulations, and/or the PDL regulations.

Employers must generally maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees created for FMLA/CFRA/PDL purposes as confidential medical records in separate files/records from the usual personnel files. Employers are required to comply with applicable law regarding the confidentiality of medical information requested.

Provide the Medical Certification for Employees form to the employee for completion of Section I. The employee should then provide the form to their health care provider for completion and return within 15 days. *The employee's EFW and/or job description may be attached for review by the provider; however, it is not required.*

Employee Name	_ Department				
Employee Job Title	Employee Work Location				
Employee Regular Work Schedule:	_				
Date Certification Provided to Employee://					
Date Certification Returned by Employee://					
Supervisor Name	Supervisor Title:				
Supervisor Phone:					
Check if the employee's essential job function worksheet (EFW) i	s: Up to Date				
Check if the employee's job description is attached to certificat	ion: 🗆 Yes 🗅 No				

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