



- 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.

Patient's expected delivery date: \_\_\_\_/\_\_\_\_/\_\_\_\_

D. Chronic 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. Permanent/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. Multiple 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).

5. **If any box is checked under #4 above**, please answer the following after reviewing the statement from the employer of essential functions of employee's position, or if none provided, based upon the employee's own description of his/her essential functions:

Is employee able to perform work of any kind? (If "No", skip next question.)  Yes  No

Is employee unable to perform any one or more of the essential functions of employee's position due to the serious health condition?  Yes  No

If yes, please specify the employee's work restrictions that preclude him/her from performing essential job functions:

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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 Week \_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

7. Please provide any additional information, if needed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature of health care provider      Type of Practice      Date

Email Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

9. Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**FOR HUMAN RESOURCES/PAYROLL USE ONLY**

Verified by Human Resources/Payroll: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Name

## 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) is:       Up to Date       Attached to Certification

Check if the employee's job description is attached to certification:       Yes       No