COUNTY OF SANTA CRUZ
PHYSICIAN'S CERTIFICATION FORM

Employee Name: (print)	Employee Department:

By signing this form, I authorize the release of information necessary to process the current request for medical leave.

Employee Signature:	Date:

TO BE COMPLETED FOR THE EMPLOYEE BY THE HEALTH CARE PROVIDER

To comply with the privacy interests of employees, please do not provide information related to diagnosis (including genetic condition), treatment or other confidential medical information or records.

Please answer the below questions after reviewing the attached description of essential functions of employee's position.

1. Does the employee have an illness, injury, impairment, or physical or mental condition which constitutes a Serious Health Condition (SHC) as defined by the Family Medical Leave Act (Title 29 §825.113-825.115) and/or California Family Rights Act as described below and on reverse side of form? ☐ Yes ☐ No

   - Inpatient overnight stay in a hospital, hospice or residential medical facility
   - Continuing Treatment defined as: Incapacity and Treatment
   - Conditions requiring multiple treatments (non-chronic)
   - Permanent or Long-Term Conditions
   - Pregnancy or Prenatal Care
   - Chronic Conditions

   If yes, date medical condition started on: _____
   (date)

2. ☐ Yes ☐ No Is it necessary for the employee to be absent from work as they are unable to perform essential functions of the job without endangering self or others?

   Estimated Duration of Time Off Required: From (date) _____ **Through (date)** _____

3. If the condition is pregnancy, estimated date of delivery or scheduled C-section**:** _____

4. Intermittent Leave Treatment Plan **(if applicable):**

   ☐ Yes ☐ No Is it necessary for the employee to be absent from work for intermittent treatment (including recovery)?

   If yes: - Approximate number of occurrences/time off:

   Intermittent Time Off Required: From (date): _____ **Through (date)**: _____

   (Fill in necessary time needed) _____ **# of Days per Week or** _____ **# of Hours per Week**

   _____ **# of Days per Month or** _____ **# of Hours per Month**

   Any other instructions on specific hours, days, or time of occurrence/treatment: _____

   _____

5. ☐ Patient restrictions **(if applicable)**: **From (date):** _____ **Through (date):** _____

   Specify Any Restrictions: _____

   _____

   _____

   ☐ Yes ☐ No With these restrictions, can employee perform essential functions of the job?

6. Names of other treating health care providers: _____

HEALTH CARE PROVIDER

Provider Name (print):	Provider Signature:	
Type of Practice (field of specialization):	State License #:	
Address:	Phone Number:	Date:
City/State/Zip:	FAX Number:	

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1 Hospital Care: Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical treatment facility, including any period of incapacity or subsequent treatment with or consequent to such inpatient care.

2 Absence Plus Treatment: A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(a) Treatment* two or more times by a health care provider, by a nurse or a physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment** under the supervision of a health care provider.

3 Pregnancy: Any period of incapacity due to pregnancy, or for prenatal care.

4 Chronic Conditions Requiring Treatments: A chronic condition which:

(a) 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;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy).

5 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 or family member 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.

6 Multiple Treatments (Non-Chronic Conditions): Any period of absence to receive multiple treatments (including any period of recovery there from) 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 or more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

*Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

**A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, anti-histamines, or salves; or bed-rest, drinking fluids, exercise and other similar activities that can be initiated without a visit to a health care provider.