



Medical Certification for Family Members

This form is to be used for a Leave of Absence to care for a family member, requiring medical certification. This meets requirements of the California Family Rights Act (CFRA) and the federal Family Medical Leave Act (FMLA).

Instructions: The first three pages of this form are to be completed and signed by the patient's treating health care provider and signed by the employee. The fourth page is to be completed and signed by the patient. The entire form should be returned within 15 days as follows:

1) Staff: Payroll and Benefits Office, Salazar Hall 2nd Floor; questions may be directed to the Leave Coordinator at hleaves@sonoma.edu or fax 707-664-2024.

2) Faculty: Faculty Affairs, questions may be directed to the Faculty Affairs Office, at facultyaffairs@sonoma.edu or fax 707-664-4060.

Individuals in need of a telecommunications relay service may contact the California Relay Service at (877) 735-2929 TTY.

1. Employee's Name: _____

2. Patient's Name: _____

3. Date medical condition or need for treatment began: ____/____/____

4. Probable duration of medical condition or need for treatment: ____/____/____ - ____/____/____

(NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT)

5. The definitions below describe what is meant by a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). **Please check the box next to the appropriate category for the patient's condition.**

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

A. Hospital Care

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

B. 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:
- Treatment two or more times by a health care provider, by a nurse or 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
- 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, or for prenatal care.

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 family member must be under the continuing supervision of, but need not be receiving effective 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. 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 in order to deal with the serious health condition of the family member?

- Yes No

If the answer to 6 is yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by health care practitioner or another provider of health services, upon referral from the health care provider.

6. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
 Yes No

After review of the patient's signed statement (see page 3), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

- Yes No

Estimate the period of time care needed or during which the employee's presence would be beneficial:

____/____/____ - ____/____/____

7. When family care leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

8. _____
Signature of health care provider Type of Practice Telephone Number
Address: _____ Date: ____/____/____

9. Signature of Employee: _____ Date: ____/____/____

Authorization for Release of Medical Information

I, _____, hereby authorize _____ (physician/practitioner), to release the information on the attached Sonoma State University Medical Certification form. This information will be provided to Sonoma State University (employer) for the purpose of determining _____ (employee) eligibility for family/medical leave, as provided by state and federal law. This authorization is valid for _____(amount of time) from the date of my signature below.

I, _____ (patient), understand that I have a right to receive a copy of this authorization for the release of medical information.

Signature of Patient

_____/_____/_____
Date