SONOMA STATE UNIVERSITY

Medical Certification for Employees

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

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

1) **Staff**: Payroll and Benefits, Salazar Hall 2nd Floor. Email completed form to hrleaves@sonoma.edu or fax to (707) 664-4049. Questions may be directed to the Leave Specialist at (707) 664-2979.
2) **Faculty**: Faculty Affairs, Salazar Hall 2nd Floor. Email completed form to facultyaffairs@sonoma.edu or fax to (707) 664-4060. Questions may be directed to (707) 664-2192.
Individuals in need of a telecommunications relay service may dial 711.

1. Employee's Name:_____

2. Date medical condition or need for treatment began: _____/_____/_____

3. Date employee is expected to be able to return to work: _____/_____/_____

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

4. 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 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 the certification is for the serious health condition of the employee, please answer the following:

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? (Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussing with employee.) ❑ Yes ❑ No

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 in order to deal with the serious health condition of the employee?

❑ 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.

_____

_____

_____

7. _____ _____ _____

Signature of health care provider Type of Practice Telephone Number

Address: _____ Date:_____/_____/_____

8. 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 my 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