SONOMA STATE UNIVERSITY | FACULTY AFFAIRS & SUCCESS

MEDICAL CERTIFICATION FOR EMPLOYEES

For Use with LOA Requiring Medical Certification

This page to be completed and signed by the treating health care provider.

TO BE COMPLETED BY EMPLOYEE'S TREATING HEALTHCARE PROVIDER

Sonoma State Employee Name:

Date medical condition/treatment began:	**Return to Work Date:**

Please check the box next to the appropriate category for the patient's condition:

Serious Health Condition (FMLA & CFRA): An illness, injury, impairment, or physical or mental condition that involves one of the following:

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.

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.)
- ☐ Treatment, two or more times, by a health care provider, a nurse or physician's assistant under direct supervision of a health care provider, or a provider of health care services under orders of, or referral by, a health care provider.
- ☐ 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.

Pregnancy: *(Employee's own incapacity due to pregnancy is covered as "serious health condition" under FMLA but not CFRA.)*

- ☐ Any period of incapacity due to pregnancy, or for prenatal care.

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.)

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 not need to be receiving active treatment by, a health care provider. (e.g., Alzheimer's, a severe stroke, or the terminal stages of a disease.)

Multiple Treatments (Non-Chronic Conditions):

- ☐ Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provide 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. (e.g., cancer (radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).)

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

☐	**Yes**	☐	**No**	Is the employee able to perform work of any kind? *(If 'No' skip next section.)*
☐	**Yes**	☐	**No**	Is the employee able to perform any one or more of the essential functions of employee's position?*

If the employee is asking for intermittent leave or a reduced work load, please answer the following:

☐	**Yes**	☐	**No**	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 their serious health condition?

***If 'Yes'*:** 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:

Note: Health care provider is not to disclose the underlying diagnosis without the consent of the patient.

Health Care Provider Signature:	**Date:**

Health Care Provider Print Name:

TO BE COMPLETED BY EMPLOYEE

Employee Signature:	**Date:**

This form meets requirements of the California Family Rights Act (CFRA) and the federal Family Medical Leave Act (FMLA).

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TO BE COMPLETED BY EMPLOYEE	
I, _____ (patient), 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 the 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:**

QUESTIONS/CONTACT
This form meets requirements of the California Family Rights Act (CFRA) and the federal Family Medical Leave Act (FMLA).
If you have any questions about completing this form, please call Faculty Affairs at 664-2192 (TTY dial 711)
Please return forms, completed and signed, to: scott.graves@sonoma.edu, Director of Faculty Personnel