SONOMA STATE UNIVERSITY | Office of Faculty Affairs

MEDICAL CERTIFICATION FOR FAMILY MEMBERS

For Use with LOA for Family Care

This page is to be completed and signed by the patient's treating health care provider.

TO BE COMPLETED BY EMPLOYEE'S TREATING HEALTHCARE PROVIDER		
Empl Name:	**Patient's Name:**	
Date medical condition/treatment began:		
Probable duration of medical condition or need for treatment:	Start:	End:

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 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:

☐	**Yes**	☐	**No**	Does or will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
☐	**Yes**	☐	**No**	After review of the employee's signed statement, 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.)

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

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:	

Reset

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Top portion of this page to be completed by employee. The bottom portion to be completed by patient.

TO BE COMPLETED BY EMPLOYEE
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 period during which this care will be provided, including a schedule, if leave is taken intermittently or on a reduced work schedule.

Employee Signature:	**Date:**

TO BE COMPLETED BY PATIENT
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 (CRS 877-735-2929 TTY)
Please return forms, completed and signed, to: Sally Sacchetto, Director of Faculty Personnel