# COUNTY OF FRESNO
# HEALTH CARE PROVIDER MEDICAL CERTIFICATION FORM

**Dear Health Care Provider:**

To determine employee eligibility for state and/or federal protected leave, please complete the Health Care Provider Section on pages 1-2 of this form. If you have any questions, please call the department contact listed below. Thank you for your assistance.

## EMPLOYEE SECTION

**EMPLOYEE NAME** | **PATIENT NAME (IF NOT EMPLOYEE)** | **PATIENT RELATIONSHIP TO EMPLOYEE**

**REQUESTED LEAVE BEGIN DATE** | **ANTICIPATED LEAVE END DATE**

**DEPARTMENT CONTACT NAME** | **PHONE**

☐ By checking the box to the left, I voluntarily authorize this provider to share information necessary to confirm **chiropractic care** qualifications pursuant to FMLA and CFRA definitions.

**Employee Signature / Date**

## HEALTH CARE PROVIDER SECTION

### LEAVE DESIGNATION

Leave is for: ☐ Employee's own serious health condition ☐ Family member or designated person's serious health condition

☐ Employee's own pregnancy disability

### QUALIFYING REASON (at least one box must be checked below)

A serious health condition as defined by FMLA/CFRA is an illness, injury, impairment, or physical or mental condition that involves one or more of the following conditions. A pregnancy-related disability is defined by PDL/FMLA as any disability resulting from pregnancy, childbirth, or any other related medical condition. If the patient is under your care and meets any of these conditions, please check all appropriate boxes. If no conditions apply, please check "None of the above."

☐ **Inpatient Care** - Overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity or any subsequent treatment in connection with the overnight stay.

☐ **Incapacity Plus Treatment** - A period of incapacity for more than three consecutive, full calendar days, with treatment two or more times within 30 days of the first day of incapacity; or treatment on at least one occasion within 7 days of the first day of incapacity and results in a regimen of continuing treatment under the supervision of the health care provider.

☐ **Chronic Condition** - Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period. A chronic condition may cause episodic rather than a continuing period of incapacity.

☐ **Permanent or Long-Term Condition** - Continuing treatment for a long-term period of incapacity in which treatment may not be effective.

☐ **Condition Requiring Multiple Treatments** - Multiple treatments (including period of recovery) due to restorative surgery after an accident or other injury.

☐ **Pregnancy** - Continuing treatment for a period of incapacity due to pregnancy, childbirth, or a related medical condition.

☐ **Chiropractic** - Treatment consisting of manual manipulation of the spine to correct a subluxation confirmed by x-ray.

☐ **None of the Above**

### CAREGIVER INFORMATION

If leave is for a **family member or designated person's serious health condition,** is the employee's presence necessary or beneficial to the patient? This may include, but is not limited to, psychological comfort and/or arranging for third-party care.

☐ Yes ☐ No

**HEALTH CARE PROVIDER SECTION *(CONTINUED)***
***COMPLETION OF THIS SECTION IS REQUIRED***

**PATIENT NAME**

**DURATION OF LEAVE**

**Please specify the type and duration of leave required.**

### Temporary and Total Disability/Care

If the patient's condition warrants the need for continuous and unbroken leave/care, please designate the period below.

**LEAVE BEGIN DATE** **ANTICIPATED LEAVE END DATE**

### Intermittent Time Off

If the patient's condition warrants the need for periodic or episodic leave/care, please provide in detail the medical necessity, duration, and frequency needed.

**MEDICAL NECESSITY (E.G., FLARE UPS, REHABILITATION, DOCTOR APPOINTMENTS, ETC)**

**INTERMITTENT LEAVE BEGIN DATE** **ANTICIPATED INTERMITTENT LEAVE END DATE**

**INTERMITTENT SCHEDULE REMARKS (E.G., EXCUSED 2 HRS/DAY IF NEEDED, UP TO 5 DAYS/MONTH; OFF 2 DAYS MONTHLY; ETC.)**

### Reduced Work Schedule

If the patient's condition warrants the need for a reduced work schedule, please provide in detail the medical necessity, duration, and frequency needed.

**MEDICAL NECESSITY (E.G., LIMITED CAPACITY, RECOVERY, REHABILITATION, ETC.)**

**REDUCED SCHEDULE LEAVE BEGIN DATE** **ANTICIPATED REDUCED SCHEDULE LEAVE END DATE**

**REDUCED SCHEDULE REMARKS (MAY WORK MAX 4 HOURS PER DAY; MAX 3 DAYS/WEEK, ETC.)**

Printed Name of Health Care Provider: _____

Signature of Health Care Provider: _____

Medical Health Care Specialty: _____

Date: _____

Phone: _____

Place Stamp Here