



**MEDICAL CERTIFICATION STATEMENT**  
**Initiating Leave From Work**  
**OR Relief From Assigned Duties**

**Section 1: To be Completed by Employee**

Name of Employee: \_\_\_\_\_ CWID \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Contact Email: \_\_\_\_\_

This Certification is for the  Employee OR  Family member (complete next line)

Name of family member (patient): \_\_\_\_\_ Relationship: \_\_\_\_\_

**Medical Release (completed by Patient – Employee or Family Member):**

I authorize my provider to release medical information necessary to process the above request or clarify information regarding the employee’s need for leave, or relief from assigned duties, to a representative of the District Office of Human Resources. I understand this authorization shall remain in effect for the duration of my leave and for 90 days thereafter.

Patient’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Patient Name \_\_\_\_\_

**Section 2: To be Completed by Medical Provider**

Date Employee’s Need for Leave (or Relief From Assigned Duties) due to Own Medical Condition *or* to Care for Ill Family Member:

Began: \_\_\_\_\_ Ended (or is expected to end): \_\_\_\_\_

Does the patient’s (employee or family member) condition qualify as a “Serious Health Condition” as defined by one of the categories described at the end of this form? (Please circle) YES or NO

If yes, please check the appropriate category:

1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ None of these \_\_\_

**FOR EMPLOYEE’S OWN SERIOUS MEDICAL CONDITION**

For the duration of the medical condition as described above, and as described on the employee’s job description or as described by the employee in the absence of a job description

*Employee’s Ability to Work a Full Schedule* – The employee is able to work (regardless of functional limitations that may or may not apply):

- A full work schedule (100%)
- Some but less than a full work schedule \*
- None of his/her work schedule

\*If the employee is able to work some of his/her work schedule, but less than a full schedule, please explain and describe the extent to which the employee’s ability to work a full schedule is limited:

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*Employee's Ability to Perform the Essential Functions* – The Employee is able to perform:

- All of the essential functions of his/her position?
- Some (but less than 100%) of the essential functions? \*
- None of the essential functions of his/her position

\*If the employee is able to perform some, but less than 100%, of his/her essential functions, please explain and describe the extent to which the employee's ability to perform the functions of his or her job is limited (for example, see effort, conditions and capability examples as described at the end of this form):

FOR A FAMILY MEMBER WITH A SERIOUS MEDICAL CONDITION

The family member's medical condition requires the presence, assistance or care of the employee during the employee's hours of work? YES or NO

The employee's presence or assistance to the family member is required:

- 100% of the employee's work schedule
- Some, but less than 100% of the employee's work schedule \* (Explain below)
- None of the employee's work schedule

\*If the employee is able to work some of his/her work schedule, but less than a full schedule, please explain and describe the extent to which the employee's ability to work a full schedule is limited by the presence or assistance to the family member.

Name of Health Care Provider (Please Print): \_\_\_\_\_

Licensed Area of Practice or Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Office Phone No: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**All medical/health information is maintained in a separate confidential file.  
Access to this information is restricted by law to authorized persons only.**

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## **Serious Health Condition**

(Federal Family/Medical Leave Act; CA Family Rights Act)

1. *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.
2. *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:
  - a. Treatment by 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
  - b. 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.
3. *Pregnancy*: any period of incapacity due to pregnancy, or for prenatal care.
4. *Chronic conditions requiring treatment*: a chronic condition which:
  - a. 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; and
  - b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
  - c. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
5. *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 or family member 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.
6. *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 (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).

### **Physical Effort, Environmental Conditions and Mental Capabilities**

Examples:

1) *physical effort* – for example, reading, sitting, holding, grasping, walking, talking, bending, squatting, climbing, reaching, pulling/pushing, crawling, lifting, driving, etc.;

2) *environmental conditions* – for example, heights, outdoor weather conditions, temperatures, exposure to potential hazard conditions (gases, electricity, etc.), daytime vs. night, noise, etc.; and

3) *mental capabilities* - for example, preparing/analyzing figures; memorizing/concentrating; learning/knowledge retention; operate/use devices such as phone or computer; make group presentations; interact with others; self-regulate emotion/behavior; compose information; etc.

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