COUNTY OF SANTA CRUZ
PHYSICIAN'S CERTIFICATION FOR FAMILY CARE LEAVE

Employee Name: (print)	Employee Department:
Patient's Name: (print)	Relationship:

By signing this form, I authorize the release of any medical information necessary to process the current request for medical leave.

Patient's Signature: (Employee's signature if patient is a minor dependent)	Date:

Please describe the care you will provide to your family member and an estimate of the time period care will be needed. **If you are requesting intermittent leave or a reduced schedule, please describe the schedule of visits or treatment required:**

TO BE COMPLETED FOR THE EMPLOYEE BY THE HEALTH CARE PROVIDER

Does the patient (employee's family member) have an illness, injury, impairment, or physical or mental condition which constitutes a Serious Health Condition (SHC) as defined by Title 29 §825.113-825.115 as described on reverse side of form? ***(Please check applicable box)***

- ☐ Inpatient overnight stay in a hospital, hospice or residential medical facility
- ☐ Continuing Treatment defined as: Incapacity and Treatment
- ☐ Conditions requiring multiple treatments (non-chronic)
- ☐ None of the above
- ☐ Permanent or Long-Term Conditions
- ☐ Pregnancy or Prenatal Care
- ☐ Chronic Conditions

Time Off for Care of a Family Member

The patient is a family member with a Serious Health Condition (SHC) which would require the employee to take time off from work to provide basic medical, personal or safety needs, transportation, or psychological comfort. The probable frequency and duration of this need is:

Duration of Time Off Required: From (date) _____ To (date) _____

or

☐ Yes ☐ No Is it necessary for the employee to be absent from work intermittently?

If yes: - Approximate number of occurrences/time off:

Intermittent Time Off Required: From (date) _____ To (date) _____

(Fill in necessary time needed) _____ **# of Days per Week** **or** _____ **# of Hours per Week**

_____ **# of Days per Month** **or** _____ **# of Hours per Month**

Any other instructions on specific hours, days, or time of occurrence/treatment:

☐ 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 statement above, is the employee's presence necessary or would it be beneficial for the care of the patient?

HEALTH CARE PROVIDER

Provider Name (print):	Provider Signature:	
Type of Practice (field of specialization):	State License #:	
Address:	Phone Number:	Date:
City/State/Zip:	FAX Number:	

Reverse Side of Forms PER1081A and PER1081B

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1 Hospital Care: Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical treatment facility, including any period of incapacity or subsequent treatment 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* two or more times by a health care provider, by a nurse or a 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 a health care provider.

3 Pregnancy: Any period of incapacity due to pregnancy, or for prenatal care.

4 Chronic Conditions Requiring Treatments: 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;

(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).

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 there from) 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 or 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).

*Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

**A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, anti-histamines, or salves; or bed-rest, drinking fluids, exercise and other similar activities that can be initiated without a visit to a health care provider.