Please Fax to: 541-367-1215 or
email jfisher@sweethomeor.gov

HEALTH CARE PROVIDER
CERTIFICATION FOR SERIOUS HEALTH CONDITION

This optional form is designed to help determine if an employee is eligible for leave under either or both the federal **Family and Medical Leave Act (FMLA)** and/or the **Oregon Family Leave Act (OFLA).**

▲ Indicates that an affirmative answer to this question is *not required* for OFLA or concurrent OFLA & FMLA leave.

***** Indicates categories that qualify as OFLA leave *only*.

Employers are *not required* to use this form in order to designate leave as OFLA or FMLA protected.

Information sought on this form relates only to the condition for which the employee is taking leave.

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) *and the Oregon Family Leave Act (OFLA)* provide that an employer may require an employee seeking FMLA*/OFLA* protections because of a need for leave to care for a covered family member with a serious health condition or *because of a need for leave due to employee's own serious health condition* to submit a medical certification issued by the health care provider of the covered family member *or a medical certification issued by the employee's own health care provider, whichever is appropriate*. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as **CONFIDENTIAL** medical records in separate files/records from the usual personnel files, 29 C.F.R. § 825.500(g), and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies. This also applies to OFLA. ORS 659A.186(2); ORS 659A.136.

Employer name: _____

Employer contact: _____

If this form is being completed for employee's own serious health condition, please also provide the following information:

Employee's job title: _____

Regular work schedule: _____

Employee's essential job functions:

_____

_____

_____

_____

Check if job description is attached: ☐

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to *patient's (your own or your covered family member's)* health care provider. FMLA/OFLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/OFLA leave due to your own *or your covered family member's* serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA/OFLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in delay or denial of FMLA protection. 29 C.F.R. § 825.313. Your employer must give you 15 calendar days to return this form. 29 C.F.R. § 825.305(b), OAR 839-009-0260(4).

Employee's Name: _____

Patient's Name (*if different from employee*): _____

If patient is a child, date of birth (mm/dd/yyyy): ___/___/_____

Patient's Relationship to Employee (*if employee is not the patient*):

☐	Spouse, *or*	☐ (**OFLA only*) Same-gender Domestic Partner
☐	Parent, *or*	☐ (**OFLA only*) Parent-in-law, *or* ☐ (**OFLA only*) Parent of employee's same-gender Domestic Partner
☐	Child, *or*	☐ (**OFLA only*) Child of employee's same-gender Domestic Partner
☐	Employee <u>is currently</u> *in loco parentis* (see definition below) to patient who is under age 18 or incapable of self-care due to disability. (Employee has financial or day-to-day responsibility for care of the patient – covered by OFLA and FMLA)	
☐	(**OFLA only*) Employee <u>was</u> *in loco parentis* to patient. (Employee had financial or day-to-day responsibility for care of the patient when the patient was under 18 – *OFLA only*)	
☐	Patient was *in loco parentis* to employee (Patient had financial or day-to-day responsibility for care of the employee *when employee was under 18*)	
☐	Grandparent (**OFLA only*)	
☐	Grandchild (**OFLA only*)	

"*In loco parentis*" means in the place of a parent, having financial or day-to-day responsibility for the care of a child. A legal or biological relationship is not required.

☐ (**OFLA only*) Check here if requesting "Sick Child Leave", which is available under OFLA for a child's non-serious health condition. (Completion of this form is only necessary *after* a 3rd occurrence of using Sick Child Leave during a "leave year".)

Employee Signature: _____

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SECTION III : For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Either your patient has requested leave under the FMLA/OFLA ***or*** *the employee listed above has requested leave under the FMLA/OFLA to care for your patient.* Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA/OFLA coverage. Limit your responses to the condition for which the employee is seeking leave.

_____	_____
Printed Name of Physician/ Practitioner	Date Signed
_____	_____
Signature of Physician/ Practitioner	Type of Practice/ Field of Specialization
_____	_____
Address	Phone Number

PART A: MEDICAL FACTS

Note: *If* this form is being used for the purposes of filing for the certification of OFLA's *non*-serious health condition of a child, only complete **# 1*.**

1) Approximate date condition commenced: _____

   a) Probable duration of condition: _____

   b) Was the patient admitted for inpatient care in a hospital, hospice, or residential medical care facility?

      No-☐ **Yes**-☐ If "yes", dates of admission: _____

   c) Date(s) you treated the patient for the condition: _____

   d) Was medication, other than over-the-counter medication, prescribed? **No**-☐ **Yes**-☐

   e) Will the patient need to have treatment visits at least twice per year due to the condition?

      No-☐ **Yes**-☐

   f) Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? **No**-☐ **Yes**-☐ If "yes", state the nature of such treatments and expected duration of treatment:

      _____

      _____

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2) Is the medical condition pregnancy? **No-**☐ **Yes-**☐ If "yes", expected delivery date: _____

3) If patient is EMPLOYEE: Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   a) Is the employee unable to perform any of his/her job functions due to the condition?

   No-☐ **Yes-**☐

   If "yes", identify the job functions the employee is unable to perform:

   _____

   _____

4) Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

PART B: AMOUNT OF CARE NEEDED When answering these questions, keep in mind that your patient's need for care may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

5) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? **No-**☐ **Yes-**☐

   If "yes", estimate the beginning and end dates for any period of incapacity: _____

   If this certification relates to the employee's seriously ill family member(s), also complete the following:

   a) Does the patient require assistance for basic medical or personal needs or safety, or for transportation? **No-**☐ **Yes-**☐

   b) Would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? **No-**☐ **Yes-**☐

   c) If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need: _____.

   Please explain the care needed by the patient:_____

   _____

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▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

Is this care medically necessary? **No**-☐ **Yes**-☐

6) Will the patient require follow-up treatments, including any time for recovery? **No**-☐ **Yes**-☐

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

_____

▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

Is this care medically necessary? **No**-☐ **Yes**-☐

7) Will it be necessary for the employee to take leave only intermittently or to work on a less than full-time schedule basis because of the condition or treatment? **No**-☐ **Yes**-☐

If "yes", expected duration: _____

Frequency (Check One):

☐ One (1) to two (2) days per month
☐ Two (2) to three (3) days per month
☐ Three (3) to four (4) days per month
☐ Other - *Explain*: _____

Please explain how employee will use leave intermittently, being as specific as possible including frequency and duration of absences: _____

8) Will the patient require a regimen of treatment? **No**-☐ **Yes**-☐

If "yes", describe the nature of the treatments: _____

_____

Estimated number of treatments: _____

Estimated interval between treatments: _____

Estimated or actual dates of treatments: _____

What is the duration (and any period required for recovery) for a treatment?

_____

▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

Is this care medically necessary? **No**-☐ **Yes**-☐

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▲ Affirmative answer to the following questions is not required for *OFLA* or concurrent OFLA/FMLA leave.

9) Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities or performing his/her job functions? **No**-☐ **Yes**-☐

▲ If "yes", is it medically necessary for employee to be absent from work during the flare-ups?

No-☐ **Yes**-☐ If "yes", please explain: _____

Affirmative answer not required for OFLA or concurrent leave

_____

▲ Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months, lasting 1-2 days):

Frequency: _____ times per _____ ☐-week(s) ☐-month(s)

Duration: _____ hours or ___ day(s) per episode

Affirmative answers not required for OFLA or concurrent leave

▲ Does the patient need care during these flare-ups? **No**-☐ **Yes**-☐

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

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