Department of Human Services/FMLA-OFLA Unit

INSTRUCTIONS for Health Care Provider:
Return this form to the patient or fax (marked CONFIDENTIAL) to the attention of:

FAX: 503-945-5866
EMAIL" FMLA-OFLA.faxes@odhsoha.oregon.gov

PHONE: 503-945-5646

INSTRUCTIONS for the Employee: This form must be completed by a physician or other health care provider.

Return it to the FMLA/OFLA Unit at the address or fax number listed above ***within 15 days*** from the request for medical certification.

Federal and Oregon Family Medical Leave

Health Care Provider Certificate of Serious Health Condition

This form relates only to the condition for which the employee is taking leave.

Employee's Name: _____ OR#_____

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

1. Relationship to employee:

☐ Child (biological, adopted, stepchild, or foster child; spouse/domestic partner's child, or the child's spouse/domestic partner)
☐ Child is 17 years or younger ☐ Child is 18 years or older
☐ Spouse or domestic partner
☐ Sibling or stepsibling or the sibling's or stepsibling's spouse/domestic partner
☐ Parent (biological, adoptive, stepparent, foster parent, or legal guardian, or the parent of your spouse/domestic partner, or your parent's spouse/domestic partner, or in loco parentis)
☐ Grandparent or grandparent's spouse/domestic partner
☐ Grandchild or grandchild's spouse/domestic partner
☐ Affinity (see definition on page 3) ☐ Related by blood

2. Nature of "serious health condition" (see page 3 for definitions): Please check the appropriate category or categories:

☐ 1-Hospital care
☐ 2-Absence plus treatment
☐ 3-Pregnancy or prenatal care
☐ 4-Chronic condition requiring treatment
☐ 5-Perm/long-term condition requiring supervision
☐ 6-Multiple treatments (non-chronic condition)

Provide a description of the medical facts that support your certification and explain how they meet the criteria of the category:

_____

_____

3. Approximate date patient's condition began: _____/_____/_____

4. If this is a chronic condition or pregnancy, is the patient presently incapacitated? (see reverse side for definition) ☐ No ☐ Yes, duration and frequency of episodes of incapacity:

_____

5. Will it be necessary for the ***employee*** to take:

a. **Full-time leave**
☐ No ☐ Yes If Yes: Effective dates: From _____/_____/____ to ____/____/____.

b. **Leave intermittently** or to work on a less than full-time schedule due to this serious health condition
☐ No ☐ Yes If Yes: Effective dates: From ___/___/____ to ___/___/____

Frequency: ☐ One - two days/month ☐ Two - three days/month ☐ Three - four days/month

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

_____

_____

c. **Reduced Schedule**:

_____

6. If the patient requires a regimen of treatment, what is the nature of and description of the treatments, an estimated number of treatments and intervals between treatments? (see reverse side for definition)

_____

_____

What are the actual or estimated dates of visits for treatment, or frequency of visits for treatment?

_____

_____

7. 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? ☐Yes ☐No
b. If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ☐ Yes ☐ No
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.

_____

_____ _____

Printed Name of Physician/Practitioner *Phone Number*

_____ _____

Signature of Physician/Practitioner *Date signed*

_____

Type of Practice/Field of Specialization

HEALTH CARE PROVIDER

Caution: Per the Genetic Information Nondiscrimination Act of 2008 (GNA) this agency is **not** requesting or requiring genetic information of its employees or their family members. We ask that you not provide any genetic information when responding to this request for medical information.

Definition of a "Serious Health Condition": an illness, impairment, physical or mental condition that involves one of the following situations:

1. **Hospital care.** Inpatient care (i.e., 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 period of incapacity or subsequent treatment relating to the same condition), that also involves:
   (a) Treatments two or more times by a licensed healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider ***or***
   (b) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under supervision of the healthcare provider.
   (1) Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment DOES NOT include routine physical, dental, or eye examinations.
   (2) 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, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or any other similar activities that can be initiated without a visit to a healthcare provider.
3. **Pregnancy.** Any period of incapacity due to pregnancy, pregnancy-related illness, or for prenatal care.
4. **Chronic conditions requiring treatments.** A chronic serious health condition is one which:
   a) Requires periodic visits for treatment by a healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider;
   b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   c) May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
5. **Permanent or long-term conditions requiring supervision.** A period of incapacity that 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 healthcare provider. Examples include Alzheimer's, a severe stroke or the terminal states of a disease.
6. **Multiple treatments (non-chronic conditions).** Any period of absence to receive multiple treatments (including any period of recovery) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either of 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).

Definition of "Incapacitated": Inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment, or recovery.

Definition of "Affinity Relationship": Affinity has the meaning given that term in OAR 839-009-0210: a relationship for which there is a significant personal bond that, when examined under the totality of the circumstances, is like a family relationship. The bond may be demonstrated by, but is not limited to the following factors, with no single factor being determinative: (A) Shared personal financial responsibility, including shared leases, common ownership of real or personal property, joint liability for bills or beneficiary designations; (B) Emergency contact designation of the employee by the other individual in the relationship or the emergency contact designation of the other individual in the relationship by the employee; (C) The expectation to provide care because of the relationship or the prior provision of care; (D) Cohabitation; (E) Geographic proximity; and (F) Any other factor that demonstrates the existence of a family-like relationship.
Please note this requires the employee to complete and submit the Affinity Attestation form in addition to this medical certification.

Directions regarding "Regimen of treatment" (question 5): If the patient is under your supervision, provide a general description of such regimen, such as prescription drugs, physical therapy requiring special equipment. If the treatments will be provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.