Douglas Education Service District

Code: **GCBDA/GDBDA-AR(3)(A)(B)**
Revised/Reviewed: 4/16/15; 3/28/16

Health Care Provider Certification

Family and Medical Leave

This form is used to provide certification per FMLA and OFLA regulations and law.

Section I: Employee Completes this Section

Employee's Name: _____

Patient's Name: _____ Employee Signature

(Please check one) Relationship to patient: ☐ Self ☐ Family Member

Section II: Health Care Provider Completes this Section

Please complete all sections and return no later than 15 days of receiving form in order to determine Family and Medical leave entitlement. (Subsequent medical verification may be required.)

Caution: Per the Genetic Information Nondiscrimination Act of 2008 (GINA) this agency is not requesting or requiring genetic information of its employees or their family members. In order for us to comply with this law, we ask that you not provide any genetic information when responding to this request for medical information.

1. Please mark all that pertains to this patient:
   a. ☐ Requires hospital care (hospice, residential care facility) ☐ Required Overnight Stay _____ (dates)
   b. ☐ Requires absence from work plus treatment ☐ Referred to other healthcare provider for treatment
   c. ☐ Pregnancy disability or requires prenatal care ☐ Expected Due Date: _____
   d. ☐ Chronic condition requiring treatment ☐ Referred to Physical Therapy
   e. ☐ Permanent or long-term condition requiring supervision ☐ Prescribed Prescription Medication(s)
   f. ☐ Requires multiple treatments for a non-chronic condition ☐ Date you treated patient: _____
   g. ☐ None of the above

2. Describe the medical facts that support your above certification. (Include condition, symptoms, diagnosis/any regimen) _____

3. Approximate date this condition began? _____

4. Probable duration of the patient' s present treatment? _____

5. Is this for either a chronic condition or for pregnancy? ☐ Yes ☐ No
   If yes, is the patient presently incapacitated? _____
   If yes, what is the expected duration of the incapacity? _____
   What is the expected frequency of the incapacity? _____

6. Will it be necessary for the employee to take time off intermittently or work on a reduced schedule due to the patient' s condition or treatment? ☐ Yes ☐ No
   If yes, what is the expected frequency for the absence? ☐ _____ days per week, ☐ _____ days per month,
   ☐ reduce hours worked in a day to _____ for _____ days per week, ☐ other (describe): _____

7. Will the patient require a regimen of treatments? ☐ Yes ☐No
   If yes, describe the nature of the treatments, number of treatments needed and the intervals between treatments:

8. If self is selected, this question applies. If a list of the employee' s essential functions/job description is not provided, answer these questions based upon the employee' s own description of his/her job functions. Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No
   If yes, identify the job functions the employee is unable to perform: _____

Additional Information/Comments or additional pages if necessary. (Identify any answer you are expounding.)

Section III. Amount of Leave Needed: Health Care Provider Completes this Section

Please complete this section to determine employee leave time.

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No
   If yes, estimate the beginning and ending dates for the period of incapacity: _____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee' s medical condition? ☐ Yes ☐ No
   If yes, are the treatment or the reduce number of hours of work medically necessary? ☐ Yes ☐ No _____
   _____
   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period. _____
   _____

3. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No
   Is it medically necessary for the employee to be absent from work during flare-ups? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

4. Based upon the employee' s medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the employee may have over the next six months(e.g., one episode every three months lasting one to two days): Frequency _____ times per _____week(s) _____month(s)
   Duration _____hours or _____ day(s) per episode.

Additional information on need of leave: _____
_____
_____

NOTE: Before an employee returns from FMLA or OFLA leave for his/her own serious health condition, the agency may require the employee to provide a statement from their medical provider verifying he/she is able to return to work, and if there are any limitations. If FMLA/OFLA eligibility cannot be determined because of missing information, an additional form may be sent.

_____	_____	_____
Signature of Health Care Provider	Printed Name of Health Care Provider	Date Signed
Field of practice: _____	Health Care Provider address: _____	

The Family Medical Leave Act (FMLA) provides that DESD may require an employee seeking FMLA leave protections because of a need for leave to care for a covered family member with a serious health condition/employee to submit a medical certification issued by the health care provider of the covered family member/employee. Employees may not be asked to provide more information than allowed under the FMLA regulations. DESD will maintain records and documents relating to medical certification, re-certifications or medical histories of employee' s family members, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630. 14(c)(1), if the Americans with Disabilities Act applies.

Return this form to the employee or to: Douglas ESD, Human Resources, Connie Rosas
Via FAX: 541-440-4770, Mail: 1871 NE Stephens, Roseburg, OR 97470, or Email: Crosas@desd.k12.or.us
Questions? Phone: 541-440-4785