North Powder
School District 8J

Code: **GCBDA/GDBDA-AR(5)**
Revised/Reviewed: 12/19/06; 8/23/16

# OFLA Medical Certification

(To be completed by health care provider)

Certification of Health Care Provider
(Oregon Family Leave Act of 1995)

1. Employee's Name _____

2. Patient's Name (if different from employee) _____

3. Does the patient's condition qualify as a serious health condition under any of the categories listed on Attachment A? ☐ Yes ☐ No

   If yes, please check the applicable category: ☐ 1 ☐ 2 ☐ 3

4. Provide a brief statement as to how the medical facts meet the criteria of the category you checked above. _____

   _____

5. What is the common name of the medical condition (e.g., cancer, diabetes, stroke, etc.) _____

6. State the approximate date the condition commenced, _____
   and the probable date employee will be able to return to work _____

7. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition? ☐ Yes ☐ No

   If yes, give the probable duration: _____

8. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

   If the patient will miss work intermittently, please indicate dates and intervals of treatment, length of treatment, frequency of treatment, recovery time from treatment.

   If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments and the provider if known.

9. If the condition is a chronic condition, or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity: _____

   _____

10. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment).

11. Is leave required to care for a family member with a serious health condition?
☐ Yes ☐ No

    If the family member will need care only intermittently or on a part-time basis, please indicate the probable duration of this need.

12. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?
☐ Yes ☐ No

    If yes, briefly describe assistance required _____

_____

_____

_____

_____ _____

Health-care Provider Date

_____ _____

Address Telephone Number

**To be completed by the employee needing family leave to care for a family member:**

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

_____ _____

Employee Signature Date

ATTACHMENT A

A "serious health condition" means: an illness, injury, impairment or physical or mental condition of an employee or family member that:

1. Requires inpatient care in a hospital, hospice or residential medical care facility such as a nursing home. When a family member resides in a long-term residential care facility, leave shall apply only to:

    a. Transition periods spent moving the family member from one home or facility to another, including time to make arrangements for such transitions;
    b. Transportation or other assistance required for a family member to obtain care from physician;
    c. Serious health conditions as described in this regulation.

2. The treating health care provider judges to pose an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future;

3. Requires constant or continuing care such as home care administered by a health care professional;

4. Involves a period of incapacity. Incapacity is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days and any subsequent required treatment or recovery period relating to the same condition. This incapacity must involve:

    a. Two or more treatments by a health care provider;
    b. One treatment plus a regimen of continuing care; or
    c. Any period of incapacity or treatment for a chronic serious health condition that requires periodic visits for treatment by a health care provider, continues over an extended period of time and may cause episodic rather than a continuing period of incapacity such as asthma, diabetes or epilepsy.

5. Involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as Alzheimer's disease, a severe stroke or terminal stages of a disease;

6. Involves multiple treatments for restorative surgery or for a condition such as chemotherapy for cancer, physical therapy for arthritis or dialysis for kidney disease that if not treated would likely result in incapacity of more than three days; or

7. Involves any period of disability of a female due to pregnancy or childbirth or period of absence for prenatal care.