Code: GDBDA/GDBDA-AR(3)(A),(B)
Revised/Reviewed: 6/09/09; 6/22/10; 2/06/18

HEALTH CARE PROVIDER CERTIFICATION
****Employee or Employee's Family Members****
Serious Health Condition
Family and Medical Leave
This form is used to provide certification per FMLA and OFLA regulations and law.

The Family Medical Leave Act (FMLA) provides that an ESD may require an employee seeking FMLA leave protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. The ESD will maintain records and documents relating to medical certification, recertifications, 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, and in accordance with 29 C.F.R § 1635.9, if the Genetic Information Discrimination Act applies.

Section I: Employee Completes this Section

Employee's name: _____

Patient's name: _____

The patient is my (**Please check one**):
□ self □ spouse □ parent □ child (age _____) □ same sex domestic partner □ parent-in-law
□ grandparent □ grandchild □ parent of domestic partner □ child of a domestic partner (age ___)

Section II: Health Care Provider Completes this Section

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA and/or OFLA. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29.C.F.R § 1635.3(e) or the manifestation of disease or disorder in the employee's family members, as defined in 29 C.F.R. 1635.3(b).

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS:

Please mark all that pertain to this patient:

1. A. □ Required overnight stay in hospice, residential care facility [admission date: _____]
   B. □ Requires absence from work plus medical treatment (other than over-the-counter)
   C. □ Pregnancy disability or requires prenatal care
   D. □ Chronic condition requiring treatment
   E. □ Permanent or long-term condition requiring supervision
   F. □ Requires multiple treatments for a non-chronic condition
   G. □ None of the above

Please return form to the patient or FAX to WESD Human Resources at 503-385-4808

2. Describe the medical facts that support your above certification.

_____

_____

3. Approximate date this condition began? _____

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

5. Is this for either a chronic condition or for pregnancy? □ yes □ no If yes, is the patient presently incapacitated? □ yes □ no If yes, what is the expected duration of the incapacity? _____

6. What is the expected frequency of the incapacity? _____

7. 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) _____

8. 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 _____

9. If the patient is not the employee, will the patient need assistance for basic medical or personal needs, or safety or transportation? □ yes □ no □ n/a patient is the employee If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? □ yes □ no

PART B: CARE NEEDED (Please complete if your patient is the employee's family member.)

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ____ No ___Yes
   If so, estimate the beginning and the ending dates for the period of incapacity: _____
   During this time, will the patient need care? _____ No _____Yes **Explain why care is medically necessary**:

_____

_____

2. Will the patient require follow-up treatments, including any time for recovery? _____ No _____ Yes
   If so, estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including recovery period: _____

_____

   During this time will patient need care? _____No ____Yes **Explain why care is medically necessary:**

_____

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3. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities requiring care on an intermittent or reduced schedule basis? _____No _____Yes

4. 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

   Does patient need care during these flare-ups? ____No ___Yes **Explain why care is medically necessary**:

_____

_____

_____ _____

Signature of Health Care Provider **Date**

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