

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 categories that qualify as OFLA leave *only*.

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: Clackamas County, Risk & Benefits Division, 2051 Kaen Rd., Oregon City OR 97045

Employer contact: Teresa Pouppirt 503-742-5477 or Shari Riedman 503-655-8577 FAX 503-742-5478

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
- Child, or (*OFLA only) Parent of employee's same-gender Domestic Partner

- Child, or (*OFLA only) Child of employee's same-gender Domestic Partner

- Employee is currently *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 was *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.

Employee Signature: _____

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

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:

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: _____

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:

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?

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

