# CERTIFICATION OF HEALTH CARE PROVIDER

Oregon Family Medical Leave (OFLA) and/or Federal Family and Medical Leave Act (FMLA)

This form ***must*** be completed by the physician or other health care provider and returned to the employee or the Seaside School District Office, 1801 South Franklin, Seaside, Oregon 97138, (503)738-5591 phone, (503)738-3471 fax.

*Information requested on this form relates only to the condition for which the patient is taking leave.*

| **Employee's Name** | **Patient's Name (if different than employee)** |
|---|---|
| | |

1. Please check the appropriate category or categories for which the above named patient qualifies under Oregon Family and Medical Leave Act (OFLA) and/or Federal Family Medical Leave Act (FMLA). Please see the reverse side of this form for explanations of "serious health condition" categories.

   ☐ (1) Hospital Care
   ☐ (2) Absence plus Treatment
   ☐ (3) Pregnancy
   ☐ (4) Chronic Conditions Requiring Treatment
   ☐ (5) Permanent/Long-Term Conditions Requiring Supervision
   ☐ (6) Multiple Treatments (Non-Chronic Conditions)
   ☐ (7) Injured or Ill Service Member
   ☐ (8) None Apply

   Describe the **medical facts** which support your certification. Please include a brief statement as to how the medical facts meet the criteria of one or more of the above categories._____

   _____

   _____

2. Approximate date condition began and probable duration: from ___/___/___ through ___/___/___

3. Is the patient presently incapacitated (inability to work, attend school, or perform other regular daily activities due to a serious health condition, treatment therefore, or recovery therefrom)? ☐ Yes ☐ No If yes, duration and frequency of episodes of incapacity: from ___/___/___ through ___/___/___ ; _____

4. Will it be necessary for the patient to take leave only intermittently or to work on a less than full-time schedule as a result of the condition or treatment? ☐ Yes (please indicate Reduced or Intermittent) ☐ No

   ☐ Reduced Schedule starting ___/___/___ Indicate number of hours per day and days per week patient may work. _____

   _____

   ☐ Intermittent Leave starting ___/___/___ Please describe schedule and length of time for intermittent leave schedule. __

   _____

   _____

   _____

5. If this certification relates to the employee's seriously ill family member or injured covered service member:
   a. Does the patient require assistance for basic medical or personal needs, safety, and/or 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: from ___/___/___ through ___/___/___ ; _____

_____ _____

**Signature of Physician/Practitioner** **Date Signed**

_____ _____

**Printed Name of Physician/Practitioner** **Type of Practice/Field of Specialization**

_____ _____

**Address, City, State, Zip** **Phone Number**

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care:** Inpatient care (i.e., an 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 subsequent treatment or period of incapacity relating to the same condition), that also involves:
    a. Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
    b. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.
        *i. Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment **does not** include routine physical examinations, eye examinations, or dental examinations.*
        *ii. 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, and other similar activities that can be initiated without a visit to a health care provider.*

3. **Pregnancy:** Any period of incapacity due to pregnancy, or for prenatal care.

4. **Chronic Conditions Requiring Treatments:** A chronic condition is one which:
    a. Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
    b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
    c. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. **Permanent/Long-term Conditions Requiring Supervision:** A period of incapacity which 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 health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions):** Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for 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), and kidney disease (dialysis).

7. **Serious Injury or Illness of a Covered Service Member:** An injury or illness incurred by the service member in the line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank or rating. A covered service member includes one who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

This form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification.