Oregon Family Medical Leave

**Health Care Provider Certification**

This form is to be completed by a health care provider and returned to the employee.

Information sought on this form relates only to the condition for which the employee is taking leave.

**Employee's Name:**

**Patient's Name** (if different from employee)**:**

1. On the reverse of this sheet is a description of health condition categories that qualify for leave under the Oregon Family Medical Leave Act. Please check the appropriate category or categories:

1-Pregnancy and/or prenatal care

2-Sick Child Leave (serious and non-serious health conditions)

1. Provide a description of the medical facts that support your certification and explain how they meet the criteria of the category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Approximate date condition began and probable duration: from \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_
2. Probable duration of patient’s present incapacity (if different): from \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_
3. If this is a chronic condition or pregnancy, is the patient presently incapacitated (see reverse side for definition)?

Yes  No If yes, please provide the duration and frequency of episodes of incapacity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Will it be necessary for the employee to take:

Full-time leave  Yes  No If yes, from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Intermittent leave or work on a less than full-time schedule  Yes  No If yes, from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Frequency: One to two days per month Two to three days per month Three to four days per month

Other: Please explain how the employee will use leave intermittently or work a less than full-time schedule, being as specific as possible regarding frequency and duration of absences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7.** If the patient requires a regimen of treatment, what is the nature of and description of the treatments, estimated number of treatments, and intervals between treatments (see reverse of this sheet for definition)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the actual or estimated dates of visits for treatment, or frequency of visits for treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the duration of each treatment and any period required for recovery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***8. If this certification relates to the employee's need to care for the employee’s child, complete the following:***

a. Does the patient require assistance for basic medical or personal needs, safety, or for 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# *Printed Name of Physician/ Practitioner Date Signed*

*Signature of Physician/ Practitioner Type of Practice/ Field of Specialization*

*Address* *Phone Number*

**HEALTH CARE PROVIDER CERTIFICATION form (continued)**

Oregon Family Medical Leave Act

**Definition of a "Serious Health Condition":**

**A "serious health condition" is defined as an illness, impairment, physical or mental condition that involves one of the following:**

**1. Pregnancy –**

Any period of incapacity due to pregnancy or pregnancy-related illness before or after the birth of the child. This category includes childbirth or pregnancy termination, or a period of absence for prenatal care, including fertility or infertility treatment.

**2. Sick Child Leave –**

An illness, injury or condition (serious and non-serious health conditions) of the employee’s child requiring home care.

**Definition of "Incapacitated":** Inability to work, attend school, or perform other regular daily activities due to the health condition, treatment therefore, or recovery therefrom.