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.