Oregon and Federal
Family and Medical Leave

Health Care Provider Certification

This form is to be completed by physician or other health care provider and returned to the employee or:

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 various "serious health condition" categories that qualify under the Family and Medical Leave Acts. Please check appropriate category or categories:

☐ 1-Hospital care ☐ 3-Pregnancy and/or prenatal care ☐ 5-Perm/long-term condition requiring supervision
☐ 2-Absence plus treatment ☐ 4-Chronic condition requiring treatment ☐ 6-Multiple treatments (non-chronic condition)

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

_____

_____

3. Approximate date condition began and probable duration: from __/__/__ through __ /__/__

4. Probable duration of patient's present incapacity (if different): from ___/___/___ through __ /___/___

5. If this is a chronic condition or pregnancy, is the patient presently incapacitated (see reverse side for definition)?

☐ Yes ☐ No If yes, duration and frequency of episodes of incapacity: _____

6. 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? ☐ Yes ☐ No If yes, duration: _____.

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 including frequency and duration of absences:

_____

6. 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 side 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? _____

7. 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, 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*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.