HEALTH CARE PROVIDER CERTIFICATION

Family and Medical Leave

PD 615A

This form is used to provide certification per FMLA and OFLA regulations and law.

Section I: Employee Completes this Section

Employee's Name: ____

Patient's Name: ____

(Please check one) Relationship to patient:

☐self ☐spouse ☐parent ☐child (age _____) ☐domestic partner ☐parent-in-law

☐grandparent ☐grandchild ☐parent of domestic partner ☐child of a domestic partner (age ___)

Section II: Health Care Provider Completes this Section

Please complete all sections in order for the agency to determine Family and Medical leave entitlement.

Caution: *Per the Genetic Information Nondiscrimination Act of 2008 (GINA) this agency is not requesting or requiring genetic information* of its employees or their family members. In order for us to comply with this law, we ask that you not provide any genetic information when responding to this request for medical information.*

1. Please mark all that pertain to this patient (descriptions are on Page 2 of this certification):

A. ☐ Requires hospital care (hospice, residential care facility)
B. ☐ Requires absence from work plus treatment
C. ☐ Pregnancy disability or requires prenatal care
D. ☐ Chronic condition requiring treatment
E. ☐ Permanent or long-term condition requiring supervision
F. ☐ Requires multiple treatments for a non-chronic condition
G. ☐ None of the above

Describe the medical facts that support your above certification. ______________________________
____
____

2. Approximate date this condition began? ______________________________

3. Probable duration of the patient's present incapacity? ___________________________

4. Is this for either a chronic condition or for pregnancy? ☐ yes ☐ no If yes, is the patient presently incapacitated?
☐ yes ☐ no If yes, what is the expected duration of the incapacity? ______________________________
What is the expected frequency of the incapacity? ______________________________

5. Will it be necessary for the employee to take time off intermittently or work on a reduced schedule due to the patient's condition or treatment? ☐ yes ☐ no If yes, what is the expected frequency for the absence?
☐_________days per week, ☐________ days per month, ☐ reduce hours worked in a day to ________for ________ days per week,
☐ other (describe) ____

6. Will the patient require a regimen of treatments? ☐ yes ☐ no If yes, describe the nature of the treatments, number of treatments needed and the intervals between treatments______________________________
____

7. If the patient is not the employee, will the patient need assistance for basic medical or personal needs, or safety or transportation? ☐ yes ☐ no ☐ n/a patient is the employee If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ☐ yes ☐ no

______________________________	______________________________	________________
Signature of Health Care Provider	**Printed Name of Health Care Provider**	**Date Signed**

Field of practice: _______________________**Health Care Provider address**: _________________________________

<u>Return this form to the patient</u> or fax to the attention of: Oregon Department of Fish & Wildlife-Human Resources at Fax # 503/947-6050 (marked-CONFIDENTIAL)

DEFINITIONS

This page defines the various serious health condition categories listed in section 1, A-G on the front of this certification. **A "serious health condition" is defined as an illness, impairment, physical or mental condition that involves one or more of the following:**

A. Hospital care: Inpatient care (i.e. overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or as a consequence of such inpatient care.

B. 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 one or both of the following:

   a. Treatment received in person, two or more times by a health care provider, a nurse, or a physician's assistant under direct supervision of a health care provider, or a provider of health care services (e.g., physical therapist) under orders of or referred by a health care provider.
   b. Treatment by a health care provider on at least one occasion resulting in a regimen of continuing treatment under the supervision of the health care provider.
   c. Regimen of Continuing Treatment: Includes a course of prescription medication such as an antibiotic or physical therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include taking over-the-counter medications such as aspirin, antihistamines or salves, bed-rest, drinking fluids, exercise, and other similar activities that an individual can initiate without a visit to a health care provider.

C. Pregnancy or pregnancy disability: Any period of incapacity for pregnancy, pregnancy-related illness including severe morning sickness, or for prenatal care or post pregnancy recovery.

D. Chronic conditions requiring treatments: A chronic serious health condition is one which:

   a. Requires periodic in-person treatments by a healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider.
   b. Continues over an extended period of time, including recurring episodes of a single underlying condition.
   c. May cause episodic rather than continuing periods of incapacity; for example, asthma, diabetes, epilepsy.

E. Permanent or long-term conditions requiring supervision: A period of incapacity that is permanent or long-term due to a condition for which treatment is potentially ineffective. The employee or family member is under supervision of a health care provider, not necessarily receiving active treatment. Examples are Alzheimer's disease, a severe stroke, the terminal stages of a disease.

F. Multiple treatments (non-chronic conditions): Any period of absence to receive multiple treatments (including any period of recovery) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider for restorative surgery after an accident or other injury, or for a condition that in the absence of treatment or medical intervention, will likely result in a period of incapacity of more than three consecutive calendar days. For example: chemotherapy or radiation for cancer, physical therapy for severe arthritis, dialysis for kidney disease.

G. None of the above: The patient does not have a serious health condition as described above.

Incapacity: The inability to work, attend school or perform other regular daily activities due to a serious health condition or treatment for or recovery from a serious health condition.

***Genetic information:** Information about: i) An individual's genetic tests; (ii) The genetic tests of that individual's family members; (iii) The manifestation of disease or disorder in family members of the individual (family medical history); (iv) An individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; or (v) The genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

Before an employee returns from FMLA or OFLA leave for his/her own serious health condition, the agency may require the employee to provide a statement from their medical provider verifying he/she is able to return to work, and if there are any limitations. The [Release to Return to Work form] is available on ODFW Inside at this hyperlink: http://inside.dfw.state.or.us/hr/forms/docs/release_to_return_to_work.pdf.