

Health Care Provider Certification

For Serious Health Condition of Employee and/or
Covered Family Member under the
Federal Family and Medical Leave Act (FMLA)

This form relates to only the condition for which the employee is taking leave

Section I: For Completion by the Employee

Instructions: Section II of this form must be completed by a physician or other health care provider. Please return it to the agency contact at the address or fax number listed at the bottom of page 2 within 15 days from the request for medical certification.

Employee Name	OR#
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Patient's name (if different from employee)

Relationship to Employee:

<input type="checkbox"/> Self	<input type="checkbox"/> Child, under age 18	<input type="checkbox"/> Child, age 18 or older and incapable of self-care due to mental or physical disability
<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent or <i>in loco parentis</i>	

Section II: For Completion by the Health Care Provider

Instructions: Return this form to the patient or fax number listed at the bottom of page 2.

1. On page 3 this form is a description of various "serious health condition" categories that qualify under the Family and Medical Leave Act (FMLA).

- | | | |
|---|--|--|
| <input type="checkbox"/> 1 – Hospital Care | <input type="checkbox"/> 3 – Pregnancy and/or prenatal care | <input type="checkbox"/> 5 – Permanent/long-term condition requiring supervision |
| <input type="checkbox"/> 2 – Absence plus treatment | <input type="checkbox"/> 4 – Chronic condition requiring treatment | <input type="checkbox"/> 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 page 3 for definition)?

No Yes If yes, duration and frequency of episodes or incapacity (# of days, weeks, months):

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

a. Full-time leave No Yes If yes, effective dates: from ___/___/___ to ___/___/___

b. Leave intermittently No Yes If yes, effective dates: from ___/___/___ to ___/___/___

Frequency One – two days/month Two – three days/month Three – four days/month

Other – Please explain how the employee will use leave intermittently, being as specific as possible including frequency and duration of absences:

c. Reduced schedule No Yes If yes, effective dates: from ___/___/___ to ___/___/___

Please specify reduced schedule:

Employee Name:	OR#:
Patient's name (if different from employee):	

Section II: For Completion by the Health Care Provider (Continued from page 1)

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 page 3 for definition)?

8. 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:

Section III: Certification

Health Care Provider's Name: (Print)			
Health Care Provider's Business Address:			
Type of Practice / Medical Specialty:			
Phone:	Fax:	E-mail:	
Signature:			Date Signed: ___ / ___ / ___

*****Please send completed form to*****

Agency Name:	Oregon Department of Fish and Wildlife		
Agency Mailing Address:	4034 Fairview Industrial Dr SE Salem OR 97302		
Agency FMLA Contact E-Mail:		Agency Fax:	503-947-6050
Agency Point of Contact Name:			
Agency Point of Contact Phone:			

Employee Name:	OR#:
Patient's name (if different from employee):	

HEALTH CARE PROVIDER

CAUTION: Per the Genetic Information Nondiscrimination Act of 2008 (GNA) this agency is not requesting or requiring genetic information of its employees or their family members. We ask that you not provide any genetic information when responding to this request for medical information.

Definition of a "Serious Health Condition": an illness, impairment, physical or mental condition that involves one of the following situations:

1. **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 consequent to such inpatient care.
2. **Absence plus treatment.** A period of incapacity of more than three consecutive calendar days (including any period of incapacity or subsequent treatment relating to the same condition), that also involves:
 - a) Treatments two or more times by a licensed healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider or
 - b) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under supervision of the healthcare provider.
 - (1) Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment DOES NOT include routine physical, dental, or eye examinations.
 - (2) 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, or any other similar activities that can be initiated without a visit to a healthcare provider.
3. **Pregnancy.** Any period of incapacity due to pregnancy, pregnancy-related illness, or for prenatal care.
4. Chronic conditions requiring treatments. A chronic serious health condition is one which:
 - a) Requires periodic visits for treatment by a healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider; Continues over an extended period of time (including recurring episodes of a single underlying condition); and May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
5. **Permanent or long-term conditions requiring supervision.** A period of incapacity that 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 healthcare provider. Examples include Alzheimer's, a severe stroke, or the terminal states of a disease.
6. **Multiple treatments (non-chronic conditions).** Any period of absence to receive multiple treatments (including any period of recovery) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either of 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), kidney disease (dialysis).

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

Directions regarding "Regimen of treatment" (question 7): If the patient is under your supervision, provide a general description of such regimen, such as prescription drugs, physical therapy requiring special equipment. If the treatments will be provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.