Human Resources
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Office: (503) 846-8606
Confidential Fax: (503)846-3720

Certification of Health Care Provider for **Serious Health Condition** Family and Medical Leave Act (FMLA) Oregon Family Leave Act (OFLA)

Other than section I, this form is to be completed by the Health Care Provider only. Once the certification is completed please forward directly Human Resources Attention "Medical Leaves". A completed Medical Certification SHOULD NOT be forwarded through employees department or supervisor. **Employees taking time off related to multiple medical conditions are required to certify each health condition on a separate Health Care Provider Certification**

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE:

The FMLA and OFLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/OFLA leave due a serious health condition. If requested by Washington County, your response is required to obtain or retain the benefit of FMLA/OFLA protections. Failure to provide a complete and sufficient medical certification within 15 calendar days from the date of your leave request may result in a denial of your FMLA/OFLA request unless an extension is approved through the County's Medical Leave Administrator. Please complete Section I, before giving this form to the medical provider.

Your name: _____
First MI Last

Department and Division: _____

Employee's job title: _____ Regular work schedule: _____

If medical certification is for Employee's own Serious Health Condition, please list your essential job functions:

_____

This certification pertains to:

- ☐ My own serious health condition
- ☐ My family members serious health condition

Family Member's Name: _____

Relationship to employee: _____

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER:

Your patient or the family member or your patient has requested leave under the FMLA/OFLA. Please answer, fully and completely, ALL applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA or OFLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

For this certification to be considered valid, any responses on this certification that has been completed or altered by any person other than you the medical provider, must be verified and initialed by the provider or medical personnel representing your office.

Completed Health Care Provider Certifications should be faxed directly from your medical office to our confidential fax line at 503-846-3720 or mailed to the address above. Washington County sincerely appreciates your cooperation.

Provider's name and business address:_____

Type of practice / Medical specialty:_____

Telephone: (_____) _____ Fax: (_____) _____

CONTINUED ON NEXT PAGE

SECTION II - PART A: MEDICAL FACTS RELATED TO PATIENT

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

___ No ___ Yes If so, dates of admission:_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No ___ Yes

Was medication, other than over-the-counter medication, prescribed? ___ No ___ Yes

This question is for Chiropractors only: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. Regarding your patient, was a subluxation of the spine identified by X-ray? ___ No ___ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment?(e.g., specialist, physical therapist)
___ No ___ Yes If yes, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy?___ No ___Yes If so, expected delivery date: _____

3. Is the patients condition related to a serious health condition that resulted in a permanent or long-term incapacity, for which treatment may not be effective but is under the continuing supervision of a health care provider (e.g., Alzheimer's, severe stroke, terminal stages of a disease)? ___ No ___ Yes

4. Describe relevant medical facts related to the condition for which the employee seeks leave (medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment)

_____

_____

5. Use the information provided by the employee in Section I to answer this question. If the condition relates to the employes own health condition and Washington County did not provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? ___ No ___ Yes

If so, identify the job functions the employee is unable to perform:

_____

SECTION II - PART B: AMOUNT OF LEAVE NEEDED

6. Will the employee or their family member be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___ No ___ Yes

If so, estimate the beginning and ending dates for the period of incapacity:_____

7. Will the employee need to attend follow-up treatment appointments, work part-time or on a reduced imtermittent schedule because of the medical condition? ___ No ___ Yes

If so, are the treatments or the reduced number of hours of work medically necessary? ___ No ___ Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

_____

CONTINUED ON NEXT PAGE

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

8. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ___ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?

___ No ___ Yes. If so, explain how employee will use leave intermittently, being as specific as possible:

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ____ day(s) per episode

SECTION II - PART C: IF THIS CERTIFICATION RELATES TO THE CARE OF AN EMPLOYEES FAMILY MEMBER

When answering these questions, keep in mind that your patient's need for care may include assistance with basic medical, hygienic, nutritional, safety, or transportation needs, or for the provision of physical or psychological care.

9. Does the patient require assistance with basic medical or personal needs or safety, or for transportation?
____No ____Yes

If yes, please explain the care needed by the employee:

_____

_____

What is the probable duration the employee will need to take off work or assist the patient?

_____

If the patient will need care only on an intermittent basis, please indicate the probable duration and frequency.

_____

Would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ____No ____Yes

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GINA: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. (75 Fed. Reg. 68934)

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**