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.

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 (marked CONFIDENTIAL) to State Personnel, Attn: AGP, Oregon Military Department, Fax (503) 584-3556.

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.