|  |
| --- |
| ***Click here to enter a date*** |
| ***Click here to enter First and Last Name*** |
| ***Click here to enter Street Address*** |
| ***Click here to enter Agency City, State Zip*** |
| **Subject: Family & Medical Leave – Request for Medical Certification** |

|  |
| --- |
| Federal Family and Medical Leave (FMLA) and/or Oregon Family Leave (OFLA) protected leave for chronic conditions must be recertified with updated information from your healthcare provider annually, or anytime there is a significant change in your leave use. The purpose of this letter is to request an updated Health Care Provider Certification form for your Family & Medical Leave condition identified as ***Click here to enter Qualifying Event*** due to: |
| |  |  | | --- | --- | |  | Your last Health Care Certification form was received on ***Click here to enter a date*** | |  | You are currently approved for ***Click here to enter Current Approval***, however; you have been using leave at the rate of ***Click here to enter Current Rate of Use***. |   Please take the provided certification form to the attending physician. Return the certification and any required attachments to the agency ***within fifteen (15) days*** from the date of this letter. The law requires we inform you that if you fail to return the required certification it may result in a denial of leave in accordance with law, policy, or a collective bargaining agreement. | |

|  |  |
| --- | --- |
| **Signature:** | ***Click here to enter your name/signature*** |
| **Position:** | ***Click here to enter Your Position or Title Name*** |
| **Phone:** | ***Click here to enter Phone Number(s)*** |
| **Fax:** | ***Click here to enter Fax Number*** |